



**CATHOLIC RELIEF SERVICES  
KENYA PROGRAM**

**CRS/MBEERE  
CHILD SURVIVAL  
PROJECT**

**Award No. HFP-A-00-02-00041-00  
OCTOBER 1, 2002 – SEPTEMBER 30, 2007**

**Midterm Evaluation Report  
(July 25 – August 11, 2005)**

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**Submitted to**

**USAID**

## ABBREVIATIONS

ACT	Artemisanin (Coartem) Combined Therapy
AIDS	Acquired Immunodeficiency Deficiency Syndrome
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CB	Capacity Building
CBMS	Community-based Monitoring System
CDD	Control of Diarrheal Disease
CF	Community Facilitators
CHU	Community Health Unit
CHW	Community Health Worker
C-IMCI	Community IMCI
CORE	CS Collaborative & Resources Group
CORPS	Community Own Resource Persons
CR	Country Representative
CRS	Catholic Relief Services
CS	Child Survival
CSP	Child Survival Project
CSTS	Child Survival Technical Support Project
CU5	Children Under-Five
DAP	Detailed Activity Plan
DASCO	District AIDS and STI Coordinator
DHC	Dispensary Health Committee
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DOE	Diocese of Embu
DSSD	Development and Social Services Department, Diocese of Embu
EBF	Exclusive Breastfeeding
EOP	End of Project
EPI	Expanded Program on Immunization
EARO	East Africa Regional Office
FACS	Food Assisted Child Survival
FGD	Focus Group Discussion
FP	Family Planning
GM	Growth Monitoring
GoK	Government of Kenya
HFA	Health Facility Assessment
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HQ	Headquarters
IEC	Information, Education, Communication
IHAP	Integrated Health and Agriculture Program
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IR	Intermediate Results
ITN	Insecticide-treated Net
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KEPI	Kenya Expanded Program for Immunization

KFSC	Kenya Food Security Consortium
KPC	Knowledge, Practice and Coverage Survey
Ksh	Kenya Shilling
LAM	Lactation Amenorrhea Method
LOP	Life of Project
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCSP	Mbeere Child Survival Project
MEDS	Mission for Essential Drug Supplies
MIS	Management Information System
MOH	Medical Officer of Health
MOA	Ministry of Agriculture
MOEST	Ministry of Education, Science and Technology
MOH	Ministry of Health
MOU	Memorandum of Understanding
MOWR	Ministry of Water Resources
MTCT	Mother-to-Child Transmission
MTE	Midterm Evaluation
MTMSG	Mother-to-Mother Support Group
NASCOP	National AIDS/STD Control Program
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PCBD	Peach and Capacity Building Department
PCM	Pneumonia Case Management
PHMT	Provincial Health Management Team
PMCT	Prevention of Mother-to-Child Transmission
PMO	Provincial Medical Officer
PQSD	Program Quality and Support Department
PVO	Private Voluntary Organization
RCQHC	Regional Center for Quality of Health Care
RH	Reproductive Health
RTI	Reproductive Tract Infection
SCM	Standard Case Management
SP	Sulfadoxine/ Pyrimethamine (Fansidar)
STA	Senior Technical Advisor
STI	Sexually Transmitted Infections
TOT	Training-of-Trainers
TT	Tetanus Toxoid
TB	Tuberculosis
TBA	Traditional Birth Attendants
UNDP	United Nations Development Program
USAID	United States Agency for International Development
USCCB	United States Conference of Catholic Bishops
VCT	Voluntary Counseling and Testing
VHC	Village Health Committee
WHO	World Health Organization
WRA	Women of Reproductive Age

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## A. Executive Summary

The goal of the five-year Child Survival project is to sustainably reduce under-5 mortality and morbidity in the Divisions of Mwea and Gachoka of Mbeere District by improving the capacity of caretakers and health care providers to prevent and manage targeted childhood illnesses. The total population is 173,000, of which 78,957 are women of reproductive age and 31,140 are children under five years of age. The project is addressing the principal causes of child morbidity and mortality through HIV/AIDS (15%), Nutrition and Micronutrients (30%), Pneumonia Case Management (25%), and Improved Control of Malaria (30%).

Overall, the MCSP is doing very well. The project is following the work plan and is on target with all activities. There is considerable progress being made in the program, as demonstrated throughout the results of this MTE report. To date, the main accomplishments of the program include the establishment of two VCT/PMTCT sites, implementation of IMCI and the initiation of C-IMCI in Mbeere District, the training of 340 CHWs, the formation of 32 Mother-to-Mother Support Groups, the formation and training of 72 Dispensary Health Committees, and the establishment of 72 growth monitoring sites.

There are a few issues that will need to be addressed over the next year of the project, however, these were all discussed in detail with the staff during the MTE. In fact, most of the issues were raised by the staff themselves, and the staff also came up with solutions for nearly every problem which they are facing. The main constraints, problems and areas in need of further attention include arrangements for treatment of VCT/PMTCT clients found to be HIV positive when tested, and the lack of a comprehensive and systematic approach (computerized spread sheet program like Excel) for analyzing and using data and information for program monitoring and decision-making.

Capacity building effects of the program have been very successful, yielding tremendous results to date in terms of standard case management at the health facility level, and indications that behavior change is occurring at the community and household levels. The program staff have also increased their skills and abilities, and have demonstrated considerable program achievements during the first half of the program.

Prospects toward sustainability are mostly positive, with the exception of “volunteerism” by community resource persons and their remaining active once the project ends. Plans for phase out have been made, however the program has not yet begun implementing them. This will be carried out during the second half of the program.

Recommendations have been developed for both the technical areas of the program, and for program management. Technical recommendations mostly deal with reinforcing and strengthening existing activities and approaches, while program management recommendations deal with issues of communication and standardization of the HIS and use of data for program monitoring and decision making.

In conclusion, the MCSP team is very strong and loyal, and there is incredible team spirit and commitment toward the project. The staff are working very hard, and have every right to be proud of their activities and the results they are achieving in Kenya. There is no doubt that they will continue to produce excellent results and demonstrate impact in the communities with which they are working.

## B. Assessment of Progress Made Toward Program Objectives

### 1. Technical Approach

#### a. Project Overview

CRS Kenya is in its third year of implementing a five-year USAID centrally funded child survival project in two of the four divisions of Mbeere District, namely Mwea and Gachoka Divisions. The goal of the five-year Child Survival project is **to sustainably reduce under-5 mortality and morbidity in the divisions of Mwea and Gachoka of Mbeere District by improving the capacity of caretakers and health care providers to prevent and manage targeted childhood illnesses**. The total population of the district is 173,000, of which the two project divisions have a total of 42,805 women of reproductive age and 17,960 children under-five years of age.

The project is addressing the principal causes of child morbidity and mortality through the following interventions and objectives:

#### **Nutrition and Micronutrients (30%)**

- 1.1 Improved feeding practices of caretakers with children <24 months
- 1.2 Improved micronutrient intake for children <5 years and postpartum women

#### **Improved Control of Malaria (30%)**

- 2.1 Improved caretaker knowledge and practice on malaria prevention
- 2.2 Improved caretaker health-seeking behavior on management of malaria in children < 5 years old
- 2.3 Improved facility level management of malaria

#### **Pneumonia Case Management (25%)**

- 3.1 Increased caretaker knowledge of and treatment of children < 5 years with pneumonia
- 3.2 Improved health workers management of pneumonia in children < 5 years

#### **HIV/AIDS (15%)**

- 4.1 Improved Access of WRA to VCT services
- 4.2 Improved access to PMCT services for HIV+ pregnant women

Program strategies include the Integrated Management of Childhood Illnesses (IMCI), Community IMCI (C-IMCI), Prevention of Mother to Child Transmission of HIV infection (PMTCT), Voluntary Counseling and Testing for HIV (VCT), and Insecticide Treated Bed nets (ITN) for malaria. Cross-cutting strategies include social mobilization, capacity building, and behavior change communication at all levels of the project including community, local administration, health facility, and partner organizations.

CRS project partners include the Dioceses of Embu (DOE) who is the local implementing partner, the Ministry of Health (MOH) at the national, provincial and district levels, and Population Services International (PSI) who is assisting with the provision of insecticide treated bed nets (ITN) and training on their sale and use. Other collaborating partners include Christian Community Services (CCS), Community Capacity Support Program (CCSP), African Medical Research Foundation (AMREF), Liverpool, World Vision, PLAN International, and the United Nations World Food Program (UNWFP).

At the community level, partners include community health workers (CHW), mother-to-mother support groups (MTMSG) led by community facilitators (CF), dispensary health committees (DHC), other community groups (women's groups, youth groups, church groups, political groups, opinion leaders, political leaders), and the local administration (chiefs, assistant chiefs, village elders).

The program implementation started on October 1, 2002 and will end on September 30, 2007. The level of funding is \$1,336,810 from USAID and cost sharing of \$494,437 from CRS for a total funding level of \$1,831,247. The annual cost per direct beneficiary is \$6.30.

## **b. Intervention Areas – Progress Report**

This section contains information on the intervention areas and the related activities that are being carried out in order to achieve progress toward impacting the project indicators. The intervention areas and the indicators are the same as those described in detail in the DIP, and no changes in the technical approaches have been made to date.

The interventions are effective, and the activities are demonstrating progress toward the project objectives as quantitatively and qualitatively measured during the mid-term evaluation. While a few issues have been raised which need to be addressed over the second half of the project, the project is on track and the work plan is being closely adhered to. Please see the Results Summary Chart following the text on the interventions in this section.

CRS is providing technical and financial support to the implementing partner, the Diocese of Embu (DOE), who is training health facility staff from the MOH and community-own-resource-persons (CORPS - community health workers, community facilitators, mother-to-mother support groups, and other community leaders) to implement project activities at the facility and community levels.

## IMCI/C-IMCI

The project is using the IMCI strategy to address the technical interventions.

<u>Activities</u>
<b>IMCI/C-IMCI</b>
<ul style="list-style-type: none"> <li>• IMCI training at facility level for malaria, pneumonia and diarrhea</li> <li>• Joint supportive supervisory visits by DHMT and DSSD to health facility staff</li> <li>• CHW training in C-IMCI for malaria, pneumonia and diarrhea</li> <li>• Joint supportive supervision visits by DHMT and DSSD to CHWs</li> <li>• Strengthening of referral systems between CHWs and health facilities</li> <li>• Management training of DHC members (to include financial management &amp; accountability, logistics, procurement, governance, and leadership skills)</li> </ul>
<b>Nutrition</b>
<ul style="list-style-type: none"> <li>• Identify mothers with children &lt; 6 months; qualitative study on constraints of EBF.</li> <li>• Community education on breastfeeding, nutrition and micronutrients</li> <li>• Nutritional counseling for caretakers of malnourished children &lt;24 months</li> <li>• Breastfeeding and appropriate feeding promotion through mother to mother support groups</li> <li>• Revision of nutritional counseling cards for appropriate vitamin A and hygiene messages</li> <li>• Monthly growth monitoring of children under 24 months by CHWs</li> <li>• Train CHWs and health facility staff on EBF and vitamin A</li> <li>• TBAs and CHWs identify postpartum women</li> <li>• Link with IHAP agricultural project for promotion of Vitamin A rich foods</li> </ul>
<b>Diarrhea</b>
<ul style="list-style-type: none"> <li>• Establish ORS corners in each of the health facilities</li> <li>• Train health facility staff on preparation and administration of ORS</li> <li>• Education of CORPS and community members on the preparation and administration of ORS, and on hand washing</li> </ul>
<b>Pneumonia</b>
<ul style="list-style-type: none"> <li>• Development of BCC strategies for improved pneumonia recognition, care seeking and treatment</li> <li>• Education of CORPS and community members on recognition, treatment and appropriate care for pneumonia</li> </ul>
<b>Malaria</b>
<ul style="list-style-type: none"> <li>• Development of BCC strategies for malaria prevention and control, recognition, care seeking, and treatment</li> <li>• Education of CORPS and community members in malaria prevention, treatment and control strategies</li> <li>• Coordination with PSI to establish ongoing community-based ITN distribution and sales</li> <li>• CHWs involved in ITN sales and SP distribution</li> </ul>

CRS Kenya staff have been actively involved in IMCI with the MOH at the national level through participation in the National Task Force on IMCI, where they are advising the government on policy as well as technical issues, and helping to set the stage for national uptake of IMCI.



While IMCI is a relatively new concept for the provincial health management team (PHMT), the training of MOH staff at all levels is underway, and the support they are receiving from the MCSP in Mbeere District is helping them establish their province as an IMCI center of excellence from where lessons learned can be used to help scale up IMCI throughout the country. The province now has their own IMCI trainers and facilitators which will help them train their remaining staff on IMCI, and provide refresher training on an ongoing basis. They are currently at around 40% capacity, and are working toward their goal of 60-70% coverage. However, they are also dealing with issues of cost and trained staff being reassigned out of the province. They are looking at on-the-job training as a possible solution to the high cost of expansion of IMCI throughout the entire province.

The District Health Management Team (DHMT) in the Mbeere child survival project area is very supportive and involved in project activities. They appointed a district IMCI focal person who is the district clinical officer. The DHMT is actively involved in IMCI training at the facility level for malaria, pneumonia and diarrhea case management, and mobile growth monitoring (GM) sites for GM, nutrition and micronutrient activities. They regularly conduct bi-monthly joint supportive supervisory visits with the project staff to the health facilities to work with the health facility staff and the attached CHWs, as validated through record reviews and interviews during the MTE.

Through this project, CRS has taken the lead in piloting the home management component of C-IMCI in Kenya. They are using the training modules developed by CRS HQ to assist CHWs in skills development and activity management at the community level. The DCH/MOH in Kenya has adopted these CRS C-IMCI guidelines, which have now been translated into several Kenyan languages and are being rolled out to all parts of the country.

For C-IMCI, the PHMT did not want to move too quickly and have the community trained and demanding services before the health facility staff had been trained and were able to provide those services. Once the facility staff training has been completed, the provincial health staff will be ready to address C-IMCI with communities in order to increase health seeking behavior.

The DHMT is also involved in CHW training on C-IMCI for nutrition and micronutrients, malaria, pneumonia and diarrhea, and ensuring that the referral system is in place and working well. Data from the MTE showed that referrals by CHWs to the health facilities have increased since the beginning of the project, and GM sites have considerably improved the utilization of CHW and health facility staff services at these mobile outreach sites. Several facilities are still not collecting data on CHW referrals, and not all CHW referred patients are seeking care at a health facility due to lack of transportation and cost. Nor is a counter referral or information being sent from the health facility back to the CHW.

*Recommendation*

The project should continue strengthening the referral system, including monitoring of the system, to ensure appropriate follow up by a skilled health provider of referred patients, and to accurately reflect CHW referrals to health facilities. The issue of counter-referrals from the health facility back to the CHW should also be explored to further improve follow up of sick children at the community level and to reinforce sustainability of the system.

Management training for the dispensary health committee (DHC) included financial management & accountability, logistics, procurement, governance, and leadership skills. To date, 72 DHCs have been trained and are effectively operational. For a more detailed discussion of the DHCs, please see the capacity building and sustainability sections below.

The 2003 IMCI Supervision and Follow-up Report revealed that job aides were available and being utilized, 71% of all cases seen were correctly assessed for general danger signs, and over 86% of children seen had their weight taken and their immunization and vitamin A status checked, and provided where necessary. Assessment of feeding problems and counseling was effectively done by over 82% of the health workers observed. Special reports on the follow up supervision for IMCI trained health facility staff have been produced by the project after each IMCI training carried out, and can be found in the annex of this MTE report.

The MTE focus group discussions and the health facility assessment revealed that health facility staff continue to demonstrate clinical excellence in their ability to correctly assess, classify and treat diarrhea, pneumonia and malaria. The average health worker score for the assessment, classification and treatment of children aged two months to five years was 98%, while the same health staff scored 100% for the newborn to two month age group. Please refer to the Results Summary Chart below and the health facility assessment report in the annex.

The project has included C-IMCI as a strategy, however the training activities have only just begun, and there are only two teams of CHWs trained on it so far. The remaining CHWs will be trained over the next year.

**Nutrition**

Nutrition and micronutrients (vitamin A) have been included under IMCI in this project to ensure that a truly integrated approach is being used to address childhood diseases at both the facility and community levels. Exclusive breastfeeding, mother-to-mother support groups (MTMSG), nutritional counseling, and growth monitoring (GM) are the major activities under this intervention area.

The baseline KPC survey conducted at the beginning of the project revealed poor results with exclusive breastfeeding (EBF) and it was therefore recommended that the project undertake a qualitative study to further explain the data on EBF in the project area. A study on the "Perceptions and Practices of Breast Feeding in Mbeere District

Kenya: A Qualitative Study” was completed in April 2004 in response to the need to evaluate barriers to exclusive breastfeeding practices. “The data clearly demonstrated that the interplay of the structural and practical aspects of the mother’s life and perceptions concerning breastfeeding and maternal milk as well as norms defining and guiding male and female family roles and division of labor contributed to the lack of both practicing exclusive breastfeeding as well as to a negative attitude toward the idea.” Based on the extensive findings of the study (see Annex) the following recommendations were made:

#### **Breastfeeding Study Recommendations**

1. Education and skill building to TBAs, CHWs and providers of ant-natal care
2. Dissemination of MOH infant feeding policy to leaders and service providers
3. Clear IEC materials developed, displayed and distributed
4. Community based interventions and involvement such as:
  - a. Home based visits by CHWs and other health workers
  - b. Formation of mother to mother support groups
  - c. Education of all stake holders including fathers, care givers, youth, leaders
  - d. Campaign to “Feed the mother, who feeds the child”
5. Training for mothers in better lactation management
6. Correct misconceptions such as the necessity of giving water and the inadequacy of milk as a unique diet for infants
7. Advocacy for EBF
8. Enhancement of linkages between CRS, MOH, NGO’s and community groups
9. Development of strategies to feeding practices of HIV positive mothers
10. Strengthened integration of EBF support into growth promotion activities
11. Examination by MCSP of project objectives and indicators related to breastfeeding and their modification to detect smaller changes.

In response to these recommendations, MCSP and MOH staff were trained on TOT for MTMSG. They then trained 32 MTMSG community facilitators (CF) who then formed the mother to mother support groups (MTMSG), and are currently leading them. Discussions and information shared in the groups include the physiology of breast milk production, feeding, engorgement and other problems, positioning and attachment, early initiation, nutrition during breastfeeding (for the mother), and breastfeeding under difficult conditions such as HIV positive mothers, beliefs and taboos affecting breastfeeding and weaning. The CF routinely advocates for EBF in their communities, and they role model the behavior wherever possible.

The project developed IEC materials targeting breastfeeding, and pre-tested and revised the nutritional counseling cards to include messages on vitamin A, hand washing and other hygiene related topics and then trained the CHWs to use them. During the MTE FGD with caretakers, 25 kinds of foods were mentioned as locally available, however the community is only using less than half of them – reasons for this

were unclear and need further inquiry (cost, prohibitions, seasonality, etc.). Caretakers were able to identify vitamin A rich foods and reported using them regularly. Health education on vitamin A rich foods has been ongoing for over one year, however the new nutritional counseling cards have just been printed and about 25% of the CHWs and communities are now using them. The remaining 75% will be rolled out in the next few months. FGD with caretakers revealed hand washing practices being done using soap and water. A few caretakers said they use ash when soap is not available. Soap was observed as present in all homes visited. Caretakers stated the reason why they wash their hands is to prevent disease. They also mentioned that they wash their hands before preparing food and before feeding a baby.

The MOH policy on infant feeding was printed and a copy placed in each of the health facilities. During MTE focus group discussions with caretakers, feeding practices after illness in all groups stated increasing frequency of feeding, however they did not mention the duration for the increase (# of days). They did mention suitable foods, soft foods, and there was qualitative evidence of improved feeding practices reported. It was clear the caretakers had adequate knowledge on feeding a child more food during and after illness. They reported giving small feeds frequently during illness and more after illness. They reported a variety of vitamin A rich foods available locally. This was also observed during the home visits where the vitamin A rich foods were available in the homes.

CHWs were trained to provide health education sessions for their communities, and supportive supervision is ongoing to ensure quality and consistency of these activities. The issue of workload of mothers and caretakers was also addressed, however providing food for mothers is beyond the scope of this project. Education and skill building of TBAs was also not carried out due to the government policy change disallowing the project to involve them.

The project staff trained CHWs and health facility staff on how to conduct growth monitoring activities, with a focus on vitamin A and EBF. The health facility staff and CHWs then established 72 GM sites, and are conducting monthly GM sessions in all the project areas, where they weigh children and provide communities with education on breastfeeding, nutrition and micronutrients. During the MTE, CHWs and health facility staff were observed conducting several GM sites, and an assessment was carried out on their performance by using the quality assurance supervision checklist routinely used during monitoring visits. All MOH staff and CHWs were able to conduct growth monitoring activities with excellence, both at the facility and community levels. At the community level, the GM sites were being facilitated systematically, with three people working together, one recording, one doing the actual weighing, and one reading the weight.

An issue has arisen regarding the necessary number of GM sites. Some staff stated that it is not efficient to have a GM site within two km of a health facility because it would not be advantageous to run parallel services, but rather the GM sites should be 5-6 kilometers apart. However, the field staff felt that there should be more GM sites and

that the reduction (some GM sites have been deleted) has resulted in some mothers not weighing their children at all, and so these children are being left out.

An internal program taskforce has been established to review this situation and make a recommendation on how to proceed. Some areas had too many GM sites so supervision was impossible. With fewer GM sites, supervision is more realistic for quality control. It was stated that the task force should finish its work before deleting any more GM sites. This would include reviewing attendance at the GM sites and analyzing the quantitative data as well as FGD qualitative data. It was stated that the sites need to be strategically placed, and that it is important for the task force to share their decisions and recommendations with all the program staff, and for an opportunity to be made for discussion. This situation clearly demonstrates how well the project staff work as a team, and how the team is effectively problem solving and establishing solutions that benefit not only the project staff but also the communities and target beneficiaries of the project.

The CHWs conduct regular health education sessions on nutrition and EBF in their villages in addition to conducting the GM sites, and while they have been trained to do home visits to follow up growth faltering children, this activity is not happening as often as it needs to be done. Nutritional counseling for caretakers of malnourished children <24 months is supposed to be provided during these home visits, however additional focus on CHW training for follow up of growth faltering children is necessary. During the MTE information on growth faltering children was viewed in the record books, however CHWs had some difficulty explaining what to do with children who continued to falter. The CHWs discussed doing some home visits and providing health education to the caretakers, however when these same children continued to falter, the CHWs were at a loss about what to do.

As stated by the CRS Regional Health Advisor, “if a child has not gained weight in a given month but is still within normal parameters, the CHW currently does not do anything. Instead, the CHWs should be trained to follow up and find out why – for example, is the child sick, and if so, then the CHW should be doing a home visit to ensure catch up feeding. This is good preventive care, whereas if they did not follow this child and the child doesn’t gain weight again the following month, then that child will be underweight and below the curve. It was suggested that CHWs should not wait until the child is growth faltering before intervening, but should be proactive when children do not gain weight monthly so as to prevent growth faltering wherever possible.”

Further discussion during the MTE focused around needing to increase programmatic efforts regarding follow up for children who consistently do not gain weight from month to month by referring them to the health facilities, providing additional training for health facility staff to deal with this issue, including a discussion of follow up for specific growth faltering children during the quarterly project meetings, and developing a referral mechanism to the district hospital for these children for further assessment of other possible causes for their consistent lack of weight gain.

Initially the project intended to identify all postpartum women and provide them with vitamin A supplementation within eight weeks after delivery. However, the dosage for WRA has not been available in the country due to a legal conflict currently in the Kenyan court system. Therefore, this activity has not been carried out, and must await a resolution of the issue before the vitamin A dosage is available in the country.

Persistent drought and famine in the project area has resulted in low food production leading to moderate levels of malnutrition. Out of 12 houses visited during the MTE, one was found to have no food at all. To date, the link with the CRS IHAP agricultural project and line ministries (MOA, MO Water) has been weak, and needs to be strengthened. While they have jointly started some of the activities that were planned for in the DIP regarding the promotion of Vitamin A rich foods and other food/ nutrition/ agriculture activities, most of the activities have not been fully implemented yet. However, during the MTE much of the data suggested the need to revisit this relationship, particularly with regards to food security and sustainable agriculture for very poor families in the project area.

#### *Recommendation*

- Liaise and discuss with the CRS agriculture team and WFP regarding food security issues in the project area e.g. survey on food availability and utilization by CRS agriculture.

Exchange visits with the CRS Suba District Child Survival Project and the World Vision Kenya Child Survival Project were conducted to learn more about various activities surrounding nutrition and micronutrients, and the project staff reported that they learned a great deal through this experience and they were able to return to this project and apply several of the lessons learned as well as adapt and use some of the teaching aides such as the nutrition counseling cards.

## **Diarrhea**

The project did not include diarrhea directly in the intervention mix, however they are including a small focus on diarrhea by using the IMCI approach. Diarrhea is included in the algorithm for training of health facility staff, and most health facilities have now established ORT corners, as it is their responsibility to do so once they have received IMCI training. At the community level, CHWs are being trained on C-IMCI, and are providing health education on ORS preparation and administration. They are also being provided with ORS packets that they are dispensing to caretakers as necessary.

Focus group discussions and observation activities during the midterm evaluation demonstrated that knowledge on prevention of diarrhea is being effectively passed from the CHWs to the caretakers, and that this has been translated into practice as evidenced by hand washing with soap or ash before food preparation and feeding a child. The CHWs and caretakers both reported the importance of using ORS in the treatment of diarrhea. Other methods of diarrhea prevention mentioned during the

discussions included covering of food, water and environmental hygiene, and use of latrines.

CHWs were observed demonstrating ORS reconstitution and administration during the MTE, and a supervisory checklist was used to assess their performance. They correctly implemented all the steps, however they forgot to check the expiration date on the ORS packages. Home visits to CHW houses revealed the presence of ORS packets available for distribution to community members. ORS corners were observed in all the health facilities visited.

*Recommendation*

The CHW training on ORS should provide additional focus on checking package expiratory dates.

## **Pneumonia**

Pneumonia is covered under the IMCI training of health facility staff at the health facility level, and focuses on case management. Activities at the community level entail CHWs providing health education for community members on pneumonia recognition, care seeking, treatment by a skilled provider, and appropriate home care and follow up. CHWs are also being trained on how to assess, classify and refer pneumonia cases to the nearest health facility.

The health facility assessment completed at the time of the midterm evaluation found that each health facility had at least one in-charge trained on IMCI during the past one year, reflecting a total of over 50% of health care providers having been trained on IMCI case management in the project area. Of those trained, 100% were able to correctly assess, classify and treat pneumonia according to standard case management protocols.

Focus group discussions held during the midterm evaluation found that CHWs and caretakers were able to correctly identify at last two signs of pneumonia and included difficult breathing and fast breathing. Good practices mentioned included taking a sick child to a health facility, reducing clothing in high fever, and consulting the CHW. Despite these good practices, some harmful practices were mentioned as well and included giving sheep's urine and the use of local herbs ("rai") by some members of the community.

Over the next year the project will continue rolling out IMCI at the facility level and C-IMCI at the community level, and this should further decrease the use of harmful practices surrounding childhood pneumonia treatment by caretakers.

## **Malaria**

Malaria is included in the IMCI training of health facility staff at the health facility level, and focuses on case management. CHWs are also trained on how to assess, classify

and refer malaria cases to the nearest health facility. Initially they were also trained on how to administer SP to treat malaria, however the MOH is no longer using SP as the drug of choice in Kenya, and CHWs are not permitted to administer the new anti-malarial drugs, artemisinin (coartem) combined therapy (ACT). Therefore, treatment will no longer be a part of the activities of the CHWs in this project. Rather they will now refer all cases of fever for treatment at the nearest health facility.

Activities at the community level include CHWs providing health education for community members on malaria prevention, recognition, care seeking, treatment by a skilled provider, and appropriate home care and follow up. CHWs are also being trained on insecticide-treated bed net (ITN) distribution, sales and net maintenance including re-treatment activities, and are able to sell the nets for a small profit which provides them with an incentive. Population Services International (PSI) is providing the ITNs and also some of the training.

The ITNs were initially being purchased from PSI for 160 Ksh and sold for 200 Ksh, providing a 40 Ksh profit for the CHW. However, the MOH was selling ITNs for less in the same communities and this presented a problem for the project. The newly appointed project coordinator raised the issue at the national forum, and through countrywide discussion the issue was resolved, and PSI agreed to renegotiate the price per net down to 80 Ksh. In this project the nets are now being sold for 100 Ksh with the CHWs making 20 Ksh per net sold. The project initially purchased 1,000 nets, but the communities weren't buying them because of the reduced price by the MOH. With the price lowered, sales are now growing, and a steady supply of nets is ensured to the CHWs through PSI via the project staff.

PSI is now supplying the re-treatment tabs for ITNs, however for quite a while neither PSI nor the local market had them in stock. Therefore, re-treatment activities are just beginning in the project areas, with CHWs selling the tabs and teaching caretakers how to re-dip their bed nets every six months. During MTE observations, CHWs were able to accurately demonstrate ITN re-treatment according to the quality assurance checklist used for training and supervision activities.

The ITN promotion activities have been deemed a success of the project. However, during the second half of the project they will need to rethink their phase out activities and how to continue supplying the CHWs with nets and re-treatment tabs after the project ends. The other issue that the project needs to consider is a waiver system for very poor families who are not able to purchase ITNs even at the lower price per net. These families often don't have food in the house, and these children are most at risk of complications and mortality from malaria, and therefore need extra assistance with protection.

FGD and home visits data from the midterm evaluation demonstrated that CHWs and caretakers have increased knowledge on the prevention of malaria as well as being able to state at least two signs of malaria, including fever as one of them in every group. Practices mentioned included using an ITN, giving paracetamol, taking the child to the



health facility (not mentioning – within 24 hours), seeking advice from the CHW, and reducing clothing with high fever. Bad practices reported included going to the pharmacy, and giving the child salty water to drink.

*Recommendation*

Health education sessions on malaria need to focus on care seeking within 24 hours of fever onset, and the maintenance of bed nets once purchased (re-treatment, no holes).

Home visits demonstrated cleanliness of compounds and the lack of reservoirs for breeding. The issue of the condition of the bed nets needs to be improved in the health education sessions, as some nets were found to have holes in them. The CHWs all had ITNs available for purchase except one who sold her last ITN the day before, and was off to get a new supply today.

*Recommendation*

CHWs need to be provided with additional training on ITN maintenance, including encouraging re-dipping at the household level, and ensuring that ITNs are kept clean and free of holes and tears.

## HIV/AIDS

**Activities**

- Training in HIV counseling and laboratory testing procedures for selected dispensary workers
- Community education on VCT and PMCT
- Mother-to-mother support groups
- Development of BCC strategies for PMCT
- Training of selected dispensary workers in PMCT strategies, breastfeeding counseling
- Training of dispensary health workers in VCT sites in PMCT strategies, breastfeeding counseling
- Development of patient education materials in PMCT
- Ensuring supplies VCT; Niverapine are available at sites

The establishment of two MOH centers for voluntary counseling and testing (VCT), and for the prevention of mother to child transmission (PMTCT) has been one of the most important successes of the MCSP to date. Prior to the inception of the MCSP, there were no VCT/PMTCT services in Mbeere District, and no MOH staff trained to operate them. The CRS Program Manager has spent a lot of time working at the national level registering the two new sites and advocating at the VCT/PMTCT and Reproductive Tract Infection (RTI)/STI technical working groups. MTE data provided information on increased access to and utilization of PMTCT and VCT services in the project area. The PHMT selected one of the sites as the BEST VCT site in the province, and has forwarded this nomination to the NASCOP.

During the first half of the project, a lot of time was spent training staff and setting up the two sites.

The first site, Kiritiri, opened December 1, 2003, and now operates with four VCT counselors (one trained by PLAN and three trained by CRS), and three PMTCT counselors (all trained by CRS). Initially turnout at Kiritiri was a bit low, so the project assisted the MOH in establishing mobile testing sites that do both VCT and PMTCT. At the first mobile clinic site, turnout was so large they had to turn people away. Soon after the first site, they held a second site nearby and they were able to provide services for everyone who came. The mobile clinic sites have been held in a school where there are several rooms that can be used to organize the various services. The mobile sites use the same procedures for counseling and testing as those used in the health facilities, ensuring confidentiality.

The second VCT/PMTCT site, Karaba, opened in June, 2004. Initially there was only one staff member trained, and so when that person would leave, the site would need to close, but now there are sufficient staff and the site is always open for services. This site reported that they saw 329 clients during the first six months of this year (male 151, female 178). However, last year many more men than women were attending the VCT services, so they did a lot more mobilization with women and now the usage by females is much better. This site applied for accreditation with NASCOP, but they are still missing a few documents and will submit them shortly. NASCOP does the annual licensing, and this site has been licensed, but they are still anxiously awaiting accreditation because once they are successfully accredited they will receive a computer.

Clients	2004	2005
Male	61%	46%
Female	39%	54%

In both sites, VCT services have been established according to national guidelines, and during the MTE health staff stated they safeguard the welfare of the VCT clients by making sure that they adhere to the code of ethics of the MOH NASCOP guidelines. They also had all of the required data systems in place, including locked file cabinets to ensure confidentiality, and the procedures for all tests were present, as was the VCT protocol diagram.

Clients come in for confidential sessions where they are welcomed and made to feel comfortable. Then they are asked what has brought them in to be tested. The health care provider then contracts with the clients, which includes gaining client consent for the services and discussing issues of confidentiality. An assessment is then carried out regarding the risks that the client is taking with HIV. Information is provided on modes of transmission, and then together the client and health care provider look for options for reducing those risks. The client is then tested with two test kits for parallel sampling, which take about 15 minutes in total. A third tie-breaker test is used when the first two tests do not agree. Since starting this testing process, only two clients required tie-breakers. Finally, a post-test counseling session is conducted to encourage the client in behavior that will help them retain their negative status, or to provide information and referral for treatment for positive clients. The entire consultation takes from 45 minutes

to one hour. A couple will take a bit longer. Follow up appointments for further counseling are also scheduled for HIV and for related health needs including nutrition, opportunistic infections, ART, etc.

However, at the present time, with the newness of the program and limited services available in the area for follow up, this end of the project is still weak and will be a focus for the second half of the life of the project. Currently, HIV positive patients (except ANC clients who are part of the PMTCT services here) are referred to Embu Provincial Hospital for further testing (CD4 count test and liver function test) prior to receiving ART. Unfortunately, the CD4 laboratory machine is not working and patients are being referred to Nairobi for testing. So, even though ART is available in Embu, patients can not access treatment until they are tested, thus needed treatment is delayed. Another issue is the high cost of the CD4 test, approximately 2,000 Ksh, which is prohibitive for many poor patients, so even if the machine was working, they could not afford the test. The Embu Provincial Hospital is charging patients 250 Ksh for ART, however there is a waiver system for very poor patients. The Ishiara sub-district hospital is dispensing the ART drugs free of charge.

Both sites now have PMTCT services as well. The process is similar to VCT however after women receive their routine tests for ANC, those who are willing to be tested for HIV are then taken to the PMTCT services in the clinic. Here they receive counseling and are educated on all the issues surrounding PMTCT, and then are tested.

One of the problems with PMTCT services is that the focus is on preventing transmission to the newborns, but there is no follow-up for mothers once they test positive and have been referred to Embu for CD4 testing. A very high percentage of women have their babies at home, so those who have tested positive are given nevirapine to take at home once they begin labor. Then those women are instructed to bring their newborns back to the clinic just after birth (within 72 hours) so the newborns can receive their nevirapine. The health facilities can not give the nevirapine syrup to the positive pregnant women to administer to their newborns when they deliver at home because they have no single dose containers, only 100 ml containers. These newborns are then retested at 18 months to determine their HIV status. The positive women are instructed to breastfeed exclusively up to two months and then formula feed if affordable, and if they can't afford it then they are advised to exclusively breastfeed for six months with abrupt weaning. The mothers are also educated on the items they need for home delivery, including gloves, in accordance with the MOH guidelines and the Focused Antenatal Care Program (FANC), an MOH/ JHPIEGO program funded by USAID. **So far, not one positive woman has defaulted on monthly visits after delivery.** The issue of confidentiality prohibits the program from informing the CHWs which women are positive and in need of home based follow-up for breastfeeding and other services.

During the MTE, health facility staff reported, "the challenge is we have no ARTs to provide for clients who are positive. We give daily health talks here, but some clients don't want to be tested because there is no treatment here. Also, nutrition information is

provided to everyone, and there is nothing special to provide for HIV positive clients, so they get the general nutrition counseling that all patients receive. We need special nutrition information for HIV positive clients.”

*Recommendation*

The project may wish to consider developing special nutrition counseling cards for HIV infected women and children, due to their specific nutritional needs.

During the MTE, discussions were held on the need to address treatment issues after VCT/PMTCT services, because if the project only tests people but doesn't provide support and follow up for positive cases, then the community will stop coming to be tested and the sites will lose their credibility.

*Recommendation*

The project staff discussed the need to incorporate ART, deal with the issue of CD4 testing (both the broken machine and the high cost of testing), and start home-based care for HIV positive patients. Therefore, training on ART is needed for both the project staff and the health facility staff.

Both of the sites have established support groups for people living with AIDS, as these people need tremendous support, both financial and emotional. During the MTE it was stated that eventually the sites would also like to form clubs for all people who are tested as well.

At the end of every month, each site writes a report for that month, and it is sent to the DASCO (District AIDS and STI Coordinator), who sends it to the province to NASCOP at the MOH. If the VCT/PMTCT sites do not provide a monthly report, then they do not receive additional testing kits.

It was reported from one of the sites during the MTE that the DHMT is making sure that both sites are running, that the kits are available, and that there is always staff available so the sites remain open to offer services. They also do supervision on a weekly basis for the sites, and then there is supervision every two weeks for the VCT counselors. Since the opening, there has only been one time (for 2 months) that there was a stock-out of the reagents needed for doing the HIV testing.

In one of the sites, the nevirapine syrup expired in April '05, so CRS supplied enough for three months to one year (depending on the number of positive clients) since the government stock had not yet arrived in the country. This was a problem throughout Kenya as the suppliers took the government to court because of unfair bidding practices.

At one of the sites, it was reported during the MTE that two weeks ago they lost one mother who was HIV positive, and she was two months pregnant. “There was nothing we could do for her. She was 28 years old, and she left one child, and a husband who is

HIV positive and looked much sicker than she did. It's very demoralizing for the rest of the positive people in the support group. They expect more than you can give them."

Health staff at the VCT/PMTCT sites raised the following issues and suggestions during the MTE.

- We need more rooms to do PMTCT because women are waiting and we have two counselors and only one room.
- We need to make follow up visits, but we don't have time or transportation. Sometimes people only come once, and they test positive, and then we never see them again. We need to be able to provide follow up care. Tracing a client is very difficult due to confidentiality and we don't know where these people live.
- There is no confidentiality in PMTCT. We are concerned about the attitude of the midwives and health workers at other facilities in Embu like the provincial hospital where the staff have not received the kind of CRS training that we have. It's also a problem for the community to know the status of people who are positive. This is all very difficult. So, if the staff at the Embu Provincial Hospital and all the midwives can be trained by CRS, then that would help a lot with confidentiality.
- When it comes to the issue of following the children, there is a need for support. What next, after we find a positive child?
- We don't have the filter papers for quality control from other laboratories. The MOH is not currently providing them, but we may have them in the future.
- The public address system (megaphone) for community mobilization has been borrowed or rented, and the project needs to have its own.
- What I need is another manager to help with this place so I can practice my VCT skills. I'm so busy taking care of all the other patients at the health center that I will soon lose my VCT skills if I don't use them.
- We need some training on quality assurance, and CRS is supposed to do that during the second half of the project.
- We need a system to alert the staff when a new client has arrived for VCT/PMTCT because we are all working in the other half of the building with regular patients and we don't know when someone arrives at the VCT/PMTCT site.
- We need to fix the roof and facilities again as the termites are causing a lot of destruction.
- There is no support for the VCT staff to go for their monthly supervision meeting – no transportation or money to pay for transportation is given to us. Yet we need to be able to attend the monthly meetings with other VCT counselors so we can talk with each other and learn together, also share problems and come up with solutions together.
- We need to increase the frequency of the community mobilization for VCT clinic services at the facility and for the mobile clinics, and we need to hold monthly VCT mobile clinics.

While the project may not be able to address all of these issues sufficiently, it will be important to discuss these items with the MOH and possibly develop joint solutions.

In terms of sustainability, site staff stated, “I hope the MOH will be able to help us continue these program activities after the MCSP project ends. The MOH would need to provide kits, nevirapine, refresher training and updating seminars for the counselors, and mobilization and transportation for mobile clinics. Other health facility staff reported that “we have no problem with sustainability after the program ends. We have the kits, we have cost sharing, we have the trained personnel, and with no more transfers of staff we will be fine.”

**Results Summary Chart**

**Project Goal:** To sustainably reduce under 5 mortality and morbidity in the Divisions of Mwea and Gachoka of Mbeere District by improving the capacity of caretakers and health care providers to prevent and manage targeted childhood illnesses.

**Nutrition and Micronutrients – 30%**

Objectives	Indicators	Data Source	Project Target	Baseline Data	Mid-term Value	Final Value
<b>1.1 Improved feeding practices of caretakers with children &lt;24 months</b>	10% increase of mothers who report exclusively breastfeeding their children 0-6 months	KPC, LQAS CF register	10%	0%	29.2% <sup>1</sup>	
	30% increase of caretakers that introduce complementary food to children 6-24 months	KPC, LQAS CF register	100%	81.7%	not available <sup>2</sup>	
	20% above baseline of children 20-23 months who are still breastfeeding	KPC, LQAS CF register	100%	81.6%	not available <sup>2</sup>	
	5% increase of mothers with children <24 months who practice hand washing with soap or ash before food preparation and before feeding a child	KPC, LQAS HE report	34%	29.2%	MTE FGD <sup>3</sup>	
	30 % of children given more food than usual after an illness	KPC, LQAS HE report	48%	18%	MTE FGD <sup>3</sup>	
	15% increase above baseline of caretakers with knowledge on correct preparation and administration of ORS at household level	KPC, LQAS HE report, IMCI-HFA	64%	49%	MTE FGD <sup>3, 4</sup>	
<b>1.2.Improved micronutrient intake for children &lt;5 years and postpartum women</b>	30% increase of children 6 to 23 months old receiving Vitamin A capsules in the last 6 months	KPC, LQAS, IMCI-HFA, GM register	49%	19%	27% <sup>5</sup>	
	30% increase of women within 8 weeks post delivery receiving Vitamin A supplementation	KPC, LQAS	38%	8%	8% <sup>6</sup>	
	20% increase above baseline (about 50%) of children 6-23 months of children eating at least 2 sources of Vitamin A rich foods	KPC, LQAS	70%	50%	MTE FGD <sup>3</sup>	

<sup>1</sup> 19 MTMSG formed. 98/336 mothers practicing EBF.

<sup>2</sup> This value must be calculated using KPC LQAS survey data, which has not been repeated since the baseline. However, CF register data collection tool will be modified to try and quantify this indicator routinely to be used for monitoring purposes.

<sup>3</sup> This value must be calculated using KPC LQAS survey data, which has not been repeated since the baseline. However, qualitative data is available from the MTE.

<sup>4</sup> KPC baseline reads...caretakers who can correctly describe how to prepare ORS solution.

<sup>5</sup> The baseline was measured using the KPC. The MTE figure is measured using the project census data - 12,860 U5, and 1,047 U5 receiving vitamin A as per the GM register.  $19\% + 8\% (1047/12860) = 27\%$ .

<sup>6</sup> MOH Policy Issue – vitamin A dosages for WRA are not available in the country due to a legal conflict currently in the Kenyan court system.

**Malaria – 30%**

Objectives	Indicators	Data Source	End of Project Target	Baseline Data	Mid-term Value	Final Value
<b>2.1. Improved caretaker knowledge and practice on malaria prevention</b>	Increase 2% to 50% caretaker knowledge on use on ITN and at least one other method of malaria prevention	KPC baseline and EOP, HE report	50%	2%	MTE FGD <sup>3</sup>	
	Increase from 17% to 30% of pregnant women sleeping under ITNs the previous night	KPC baseline and EOP, ITN tracking sheet	30%	17%	22.6%	
	Increase from 10% to 20% Children <5 years sleeping under ITNs the previous night	KPC baseline and EOP, ITN tracking sheet	20%	10%	15% <sup>7</sup>	
<b>2.2 Improve caretaker health seeking behavior on management of malaria in children &lt; 5 years old</b>	Increase from 47% to 70% of caretakers of children < 5 years who recognize at least 2 danger signs for severe malaria to seek care within 48 hours (Fever is a must mention for one of the 2 signs)	KPC baseline and final, CHW reports	70%	47%	MTE FGD <sup>3</sup>	
	Increase from 68% to 80% caretaker of children <5 years with high fever in the last 2 weeks who seek care from a trained provider	KPC baseline and final, CHW reports	80%	68%	MTE FGD <sup>3</sup>	
	Increase from 20% to 50% of caretakers of CU5 with high fever receiving appropriate anti-malarials.	KPC baseline and final, CHW reports	50%	20%	MTE FGC <sup>8</sup>	
<b>2.3 Improved facility level management of malaria</b>	Increase from 20% to 50% of CU5 with fever receiving recommended anti-malaria treatment	Dispensary records, IMCI - HFA	50%	20%	MTE FGD <sup>3</sup>	

<sup>7</sup> The baseline was measured using the KPC. The MTE figure is measured using the project census data - 12,860 U5, and 1,973 U5 sleeping under ITNs as per the ITN tracking sheet.  $10\% + 5\% (1973/12860) = 15\%$ .

<sup>8</sup> MOH Policy Issue – SP is no longer being administered as the drug of choice in Kenya, and CHWs are not permitted to administer the new anti-malarial drugs.



**Pneumonia – 25%**

Objectives	Indicators	Data Source	End of Project Target	Baseline Data	Mid-term Value	Final Value
<b>3.1 Increased caretaker knowledge of and treatment of children &lt; 5 years with pneumonia</b>	20% increase above baseline of caretakers with CU5 who are able to correctly identify at least 2 danger signs of pneumonia that require seeking care within 24 hours (must mention fast/difficult breathing)	KPC baseline and EOP, HE reports, CHW register	25%	5%	MTE FGD <sup>3</sup>	
	20% increase above baseline of caretakers of CU5 who sought medical treatment for their child with cough and fast/difficult breathing within 24 hours	KPC baseline and EOP, health facility records, CHW register IMCI – HFA	72%	52%	MTE FGD <sup>3</sup>	
<b>3.2 Improved health workers management of pneumonia in children &lt; 5 years</b>	60% of healthcare workers in health facilities who appropriately classify and treat pneumonia in CU5	IMCI-HFA baseline & EOP, F/U and supervisory report	60% <sup>9</sup>	0%	42% <sup>10</sup>	

<sup>9</sup> There are 170 medical staff in Mbeere District. The project target was to train 60% (= 102) in IMCI.

<sup>10</sup> The project has now trained 72/170 medical staff in IMCI.

**HIV/AIDS – 15%**

Objectives	Indicators	Data Source	End of Project Target	Baseline Data	Mid-term Value	Final Value
<b>4.1 Improved Access of WRA to VCT services</b>	Increase from 7.5% <sup>11</sup> to 40% of WRA who utilize VCT services <sup>12</sup>	KPC, LQAS, VCT records	40%	7.5%	10% <sup>13</sup>	
	# counselors trained in VCT pilot sites	VCT training report	6	0	18 <sup>14</sup>	
<b>4.2 Improved access to PMCT services for HIV+ pregnant women</b>	# pregnant women and babies who received Niverapine for PMTCT	HFA PMTCT records	100%	0	17 WRA <sup>15</sup> 7 babies	
	# health facility staff trained in PMTCT according to standard guidelines and protocols	HFA PMTCT training report	6	0	14 <sup>16</sup>	

Kiritiri VCT/PMTCT started in December 2003.

Karaba VCT started in June 2004, and PMTCT started a year later in June 2005.

<sup>11</sup> Baseline from KPC is that of women who have been tested for HIV outside the project area as no testing facilities were available prior to the establishment of the two VCT sites that have been newly established by the project.

<sup>12</sup> VCT services include pre-test counseling, testing and post-test counseling.

<sup>13</sup> A total of 1,053 women have been tested at the two (newly established) facilities in the project area, which represents 2.5% of the total population of WRA (42,805) in the project area. (2.5% + 7.5% baseline = 10%).

<sup>14</sup> Fourteen project staff and 18 MOH staff were trained together, for a total of 32 people trained.

<sup>15</sup> A total of 29 mothers tested positive, however only 17/29 received Niverapine.

<sup>16</sup> Ten project staff and 14 MOH staff were trained together, for a total of 24 people trained.

## **2. Cross-Cutting Approaches**

The following section provides detailed information on the various approaches and strategies that are being used to implement the above technical interventions. These include community mobilization, communication for behavior change, capacity building, and sustainability.

### **a. Community Mobilization**

Initially, the project staff approached the MOH in Mbeere for partnering, and discussions were held with the provincial staff, the district staff and the health facility staff. The entry point to the community began with community leaders, including how this program would benefit their communities, and what would be required of them collectively.

Then community leaders and community members were brought together and sensitized on project goals, objectives and activities through meetings at the provincial, district and local community levels. These meetings were very well attended, and participants engaged in active discussion as well as participation in the DIP process and various meetings used to orient them to the project, resulting in their ownership of the project activities as well as their commitment to the eventual outcomes and impact on the health of their communities. The title of the project, child survival, created expectations that their children would be healthier and so they all wanted to participate. Because their name was in the title “Mbeere”, they knew it was theirs, and this feeling of ownership further encouraged them to participate fully. The project addressed the real felt needs of the community based on the data from the KPC, and this contributed to the success of the community mobilization.

At the meetings, the MOH policy, the qualities of a CHW, and the project timeframe were all shared and discussed. The community asked many questions about the objectives, and answers were provided. A MOU was established at the provincial and district levels between the DOE and the MOH specifying the roles and responsibilities of each project partner. Participatory training, planning and implementation included all the project staff and partners, which further enhanced the good relationships between everyone.

Also helpful was building on the good reputation and relationships that the DOE had already established with the entire community and administration within the project area. The capacity, skills and motivation of the MCSP staff and in particular the DOE were increased through leveraging of these existing relationships. The teamwork approach worked well as everyone planned together and had great team spirit.

Dispensary Health Committees (DHC) were then established as part of the community mobilization team to facilitate the relationship between the community and the health facility.

The community then selected 340 CHWs using the standard criteria provided to them. The CHWs actively agreed to participate in the program activities without any strings attached. Initially, volunteerism was very high. It was agreed that the CHWs would implement the program activities at the village level. (including health education, advocacy, mobilization, ORS, ITNs, GM, referral to health facilities, etc.).

CHWs were trained on health education, advocacy, mobilization, ORS, ITNs, GM, referral to health facilities, and several other topics that would help them actively engage their communities in positive health behavioral change.

GM sites were selected by the community, specifying that meetings would be held in public places. When ITNs were introduced for sale, the communities purchased them at 200 Ksh very quickly. This also helped market the project very fast.

After the first year of the program, it was decided that mother-to-mother support groups (MTMSG), were needed to reach further into the communities and impact families at the household level. Community facilitators (CF) were selected by the community to form and lead the MTMSGs.

Through increased capacity of extension workers from community mobilization, they now work together with the CHWs and CFs as a team and are able to do much more than they could have done by themselves. Community mobilization has definitely increased demand for services and utilization of the health facilities. Administratively, the extension workers were well supported with vehicles, petrol, drivers, communication phone cards, and lunch.

Currently, community mobilization is done through a number of different mechanisms. Notes are sent out, announcements are made at schools and churches, posters are hung, and loud speakers are used for mobile VCT/PMTCT and to call everyone for a meeting. Meetings are held during chief's meeting, women's groups, church groups, GM sites, community partners meetings and parents/school meetings. TBA forums and public health technicians who work for the MOH at the community level also advocate for MCSP activities.

Signifying the success of the community mobilization activities, caretakers have improved their ability to prepare and administer ORS correctly, care-seeking behaviors by attending health education sessions and following up on vitamin A, immunizations and growth monitoring for their children. With the implementation of IMCI and G-IMCI, as stated by a health worker during the MTE, **“caretakers have also begun bringing their sick children to the health facilities earlier in the illness as a result of their recognition of danger signs, and health facility workers are also providing higher quality care and case management, thus reducing the previously common serious complications of these childhood illnesses.”**

As demonstrated during the MTE, CHWs are able to accurately weigh children, and monitor vitamin and immunization status and advise caretakers appropriately. CHWs are also beginning to do more home visits for follow up care to families with underweight and sick children.

With the establishment of VCT/PMTCT services within these communities, people are now utilizing these services both at the health facility level and through mobile outreach sites.

During the MTE, project staff stated, “the DIP says that one CHW should cover 20 households with children under five. However, after doing community mobilization, it became apparent that we had to refine the program and now each CHW covers 1-3 villages with approximately 35 households with children under five. “

After community mobilization through community facilitators, the mother to mother support group strategy made it much easier to penetrate community members who required additional behavior change modification in order to conform to healthier caretaker practices.

Through community mobilization, the extension workers were able to have a much bigger impact on communities located very far away, thus providing access to health services and commodities for people who were previously isolated.

Community mobilization has allowed for program access to children under five who were defaulters and previously missed opportunities and refer them to the health facility for services.

During the MTE, the extension workers stated that, “we’ve trained 340 CHWs and many community facilitators. We’ve been the interface between the project and the community through the CHWs, and with the MOH staff at the facilities. The project staff have been capacity built very well with VCT, IMCI, PMTCT and we will soon all be trained on C-IMCI. For the prevention of HIV/AIDS we’ve been carrying out mobile VCT in the project areas, and we have mobilized the community for utilization of PMTCT/VCT services. The CHWs have played a great role in mobilizing the community, to get the under fives to come to the GM sites, and also for behavior change. The provincial administration appreciates what we are doing on the ground. Whenever the local leaders have a meeting they invite the extension workers to give a talk because they have found us to be very beneficial.

Barriers preventing community members from benefiting from the program included inadequate knowledge on the interventions which caused a low level of demand for services, and health education sessions helped rectify this problem and increase demand. Lack of transportation and far distances from communities to health facilities were rectified through the development of GM sites and VCT/MPTCT mobile clinics.

While the program is in the process of attempting to train at least 60% of the health facility staff to use IMCI, some health workers remain untrained and thus unable to do integrated case management for children under five, thereby denying community members access to IMCI services. However, with on-the-job training and linkages with other agencies, the remaining staff members are being targeted for IMCI training.

Not all health facility staff have been trained on both VCT and PMTCT. So, when the only staff member trained on PMTCT is absent, those trained only on VCT can not offer PMTCT services and vice versa. Therefore, community members do not consistently have access to all project interventions at the health facility level. To overcome this barrier, all staff working at VCT centers will need to be trained on both VCT and PMTCT.

Initially, the skills of the DHCs were very weak. Rather, they were active as individual community members until they were later trained as a group, and their collective skills improved. As an example of how community capacity has developed, DHC’s actively participated in their own training and capacity building through the MCSP, and then became very active partners in community mobilization activities as a group with respect to facilitating a strong relationship between the community and the health facility.

Poverty and inadequate food security has rendered some families with children under five to a state of constant hunger, thus making them unable to take advantage of nutrition education.

Beliefs and taboos also continue with some sections of the population who subsequently do not engage in improved caretaker practices or implementation of behavior change educational messages. To address this issue, MTMSG are attempting to influence these families through role modeling and home visits.

Project staff and health facility staff turnover and shortages delayed project implementation and some activities, thereby providing a barrier to services for some communities. Hiring and retraining of project staff have improved this situation, as have negotiations with the MOH for increased staff deployment to the area and retention of trained staff in the health facilities.

Initially, transportation presented a barrier to project implementation. The acquisition of five motorcycles and two additional vehicles improved the situation, however the field staff still need additional motorbikes so all field staff can be active simultaneously. Ten bicycles were originally procured for the CHWs, however with vast areas to cover and a large number of CHWs, additional bicycles would be needed to cover all CHWs. However, the feasibility of this expense/input may not be realistic, and issues of sustainability were also raised. Discussion on this issue ensued during the MTE, and it was decided that further discussion was needed and would follow the MTE.

Mothers and CHWs continue to spend a large amount of time walking long distances to collect water and to farm for their families, thus preventing them from fully participating in project activities such as EBF.

Two years of drought have continued to cause moderate food shortage in the project areas. The MCSP had originally planned to work closely with the CRS Integrated Health and Agriculture Program in order to address this issue by promoting drought-resistant crops and home gardens. However, while some of these activities were initiated, most are still in a nascent stage of implementation and are now planned for expansion during the second half of the life of the project.

## **b. Communication for Behavior Change**

The program's approach to behavior change is appropriate and effective. The program introduced MTMSG, and now mothers are talking about EBF together and this is seen to be influencing behavior change. After the C-IMCI training there is positive felt change where the caretakers are referring their children to the health facilities within a period of 24 hours after illness onset. Community members used to believe that eating mangos would cause malaria, however through health education and the IMCI approach they are now able to identify signs of malaria (fever) and refer accordingly. The introduction of ITNs in the community is building behavior change which is indicated by the high demand for and purchasing of ITNs. Previously, after completing their immunization schedule, children were not returning for routine growth monitoring and vitamin A supplementation. After opening the GM sites in the villages, most of the caretakers now continue taking their children for GM and Vitamin A supplements even after they complete their immunizations.

Focus group discussion data from the MTE found that all groups stated the health education sessions were useful and effective. They mentioned the advice they are getting on nutrition and EBF, saying it is beneficial because it promotes health and emphasizes disease prevention. They stated they use the information to inform other members of the community and to promote health activities e.g. cleanliness, nutrition and also establishing kitchen gardens. They cited constraints for full participation as workload for women, poverty, and ignorance among community members. When assessing CHW knowledge during the MTE, it was found that the CHWs have appropriate knowledge on the four intervention areas. They were also able to demonstrate through observation checklists that they knew HOW to do and teach the interventions. The knowledge and practice of the CHWs is translated into improved caretaker practices demonstrated by the uptake and use of ITNs, ORS, and other intervention activities, and also improved health seeking behavior by taking sick children to the health facilities. CHWs reported being satisfied due to the support given to them by the MOH and MCSP staff, and the caretakers are continuously requesting their services, as an indication of satisfaction for the services offered.

The information that the caretakers have is technically up to date as evidenced by the data of the MTE through the counseling skills on under-weights, however follow up by CHWs needs to be revised and improved. The BCC strategy goes beyond message dissemination to teach skills, for example care seeking for VCT/PMTCT services, and people are responding positively and utilizing these new services in the district. All of the IEC materials currently being used were pre-tested and found to be effective.

Feeding children mangos was thought to be a cause of malaria – however after message dissemination and HE, the community is now feeding mangos to children, and they also are using bed nets to prevent malaria. Initially many mothers found it difficult to exclusively breastfeed, but now they are practicing it because of role modeling and peer pressure.

Some harmful practices are also being abandoned by the community, such as sheep's urine for the treatment of pneumonia, and cow dung on BCG wounds and umbilicus. Instead, now they are not applying anything, and they are more inclined to keep wounds clean. Also changing the belief that cold foods cause malaria, and now caretakers are using bed nets instead. They are also seeking care from health facilities for sick children.

The effects of the behavior change activities are being measured by several tools developed for the project. The tools have been pre-tested and found to be appropriate and effective. They include community and facility tools such as ITN tracking sheets, VCT/PMTCT reporting tools, MTMSG reporting sheets, health facility registers, FGD, and CHW health education registers.

Health facility staff are now having eased work load as CHWs increase their ability to work with communities. Also, children are not as sick when they come to the health facility, thus treatment is easier and more successful.

The data on the effects of the behavior change activities is gathered and used by CHWs, DHCs, MTMSG and CFs, extension workers and other project staff, PMO, DMO, and health facility staff at weekly, monthly and quarterly meetings and during supervision and monitoring visits.

The CHWs are using their collected data to determine the type of health education to give at the GM sites, and the follow-up necessary for behavior change in order to reinforce messages and demonstrate skills at the household level.

The program has developed several innovative approaches that have been particularly successful in changing behavior amongst caretakers. These include nutrition counseling cards, C-IMCI, establishing mobile VCT/PMTCT sites and GM sites, and MTMSG targeting WRA.

### **c. Capacity Building Approach**

The capacity building objectives for the project are to increase the ability of CRS to provide technical oversight and assist the DOE in building their institutional capacity. Within the DOE, their goal is to increase their capacity to manage child survival projects as well as to grow their own organization. They are also tasked with assisting the MOH to build their capacity to implement IMCI, C-IMCI and VCT/PMTCT services.

To date, all of the MCSP project partner staff have been trained on IMCI, VCT, PMTCT, C-IMCI, MTMSG and MIS/HIS. They have also conducted exchange visits with another CRS child survival project and a World Vision child survival project. They have all been actively involved in joint supportive supervision at the various project levels, providing frequent feedback, engaging in joint planning and collaborative meetings. A Training Needs Assessment of the DOE has been carried out and the results and project response are listed below. Capacity building tools used for initial assessment and growth will also be used at the end of the project to reassess the outcomes. Plans are underway to train the staff on the two areas which have not been covered yet, including community dialogue and LQAS.

The approach used to identify capacity was based on project strategies in the implementation of the activities; IMCI, C-IMCI, VCT, PMTCT, MTMSG, and MIS/HIS. Currently there is only one tool developed to assess IMCI and this is based on the national IMCI strategy which CRS is currently involved in helping to develop. For the other areas, checklists and other monitoring tools have been developed and pre-tested, and are being used for ongoing supervision.

CRS is continually providing opportunities for their staff to increase their capacity through training, exchange visits, educational forums, and membership on task forces both nationally and internationally. Trainings continue to be organized and conducted for CRS staff at the HQ level in Nairobi and also for the DOE project staff who are based in the field. The extension workers, assistant project coordinators and the project coordinator have all grown tremendously through their involvement in this project, and all are able to demonstrate excellence in their performance both in terms of facilitating project activities and providing supportive supervision for their colleagues and counterparts. This has also been demonstrated by the fact that when the original project coordinator and two assistant project coordinators left the program, their positions were able to be filled by promoting an extension worker into the assistant project coordinator position, and by promoting an assistant coordinator into the project coordinator position.

The capacity of the development coordinator has improved as far as programming is considered. This has been demonstrated by the fact that the DOE is now developing a



strategic plan for the first time in their history. The provision of logistics to the DOE for this project has helped them facilitate their work on the MCSP, but has also helped them facilitate some of their work on other projects. This has been helpful for them in terms of their own growth, but has sometimes led to conflict within the MCSP when project vehicles have been taken for other purposes. The head of finance is actively involved in the program, although he did not participate in the MTE activities.

In April, 2003, CRS assisted the DOE in conducting an “Individual and Institutional Needs Assessment Report” on the skills, knowledge, system and structures of the Diocese. The summary of findings is included in the box below.

### **Institutional Systems and Structures**

1. Human resource management and development. As it pertains to job descriptions, there should be a revision of the current ones. This is for two reasons,

Firstly, some of the participants did not have their job descriptions with them. So, they need to be developed if they do not exist and,

Secondly, the job descriptions that available did not clearly articulate the following: -

- I. The job title- indicating the function/ department in which the job is performed and the level of the job within that function
- II. Reporting to- the persons immediate boss
- III. Subordinates- directly reporting to the job holder
- IV. Overall purpose of the job- distinguishing it from other jobs
- V. Principal accountabilities or main tasks- group the main activities into a number of broad areas, define each activity as a statement of accountability, what the jobholder is expected to achieve.
- VI. Finance management
- VII. Organizational structure
- VIII. Procurement policies
- IX. Administration
- X. Information sharing and dissemination. The information that is already available such as the vision, mission of the diocese should be disseminated. Where there is a gap as in the objectives, these should be developed by a team representative of the different arms of the diocese and the result shared with the larger group
- XI. Policies and procedures
- XII. Develop a system to coordinate and plan the diocesan development activities. This should lead to all staff being clear on their role, responsibilities and participation of all the different program activities undertaken by the diocese. Joint planning and review meetings are invaluable towards achieving good program coordination.

### **Staff Capacity Skills**

Understanding gender, training materials development, Data analysis skills, and Management skills including supervisory skills, coaching, , mentoring, planning, team building, job descriptions and task allocation

### **Computer Skills**

In the past under various project activities, CRS has supported diocesan staff computer training. In addition CRS funded projects have availed computers for the different projects. What the diocesan staff need to do now is to use the computer skills they have by doing their work using the already available resources and skills. They should use their skills to do their reports, develop training material, material for community mobilization and so on in order to enhance their ability. It is only through practice that they will become proficient in computer application. So, as far as computer skills are concerned, practice is encouraged as opposed to enrolling for a course. Skills will disappear as long as it is not utilized to the optimum.

### **Next Steps**

As a first step, it is recommended that the diocesan team share this report, review the assessment results and recommendations. The next step should be to develop a plan of action using the information. The plan should lead them to tackling the issues raised and improving the management and operational quality and efficiency of the diocese. It is important to have all the key decision makers in this forum as it maps the way forward for the diocese both in development and pastoral arms especially where there are linkages in tasks and support. This bears in mind the fact that some projects rely heavily on the parish to be operational. It is the firm belief of CRS that the DOE will use the information herein to strengthen its capacity to carry out efficient and effective development work now and in the future.

In the report, it was recommended that as a first step to bridging the identified gaps, the diocese of Embu needs to build its institutional and staff capacity in the areas identified above. To do this, the MCSP staff now hold weekly team building meetings to ensure that everyone is included in program information sharing, and that all ideas are discussed and shared. Training is also included for staff development on technical and program management issues so all team members have the skills they need to fulfill their potential.

The fact that the program coordinator and two program assistants resigned during the first half of the program caused potential setbacks with implementation. However, because the program staff who remained were well trained and loyal to the program, several of them were easily promoted to these positions and have done an excellent job in their new roles, making sure that activities are on time and are being carried out impressively well, demonstrating the high caliber of professional staff in this program.

The Project Coordinator was appointed as a member of the District Hospital Board to represent other NGOs on the board, and within the board, he has been appointed as a member of the Primary Health Care Committee, which allows the MCSP to channel the project activities in the district at a policy level.

During the MTE, a meeting was held with the Provincial Health Management Team (PHMT) who stated that, “the MCSP has benefited the province by including provincial team members in project planning, training, and evaluation activities, especially on IMCI, VCT and PMTCT. We are kept informed and we have a very good relationship with MCSP staff.”

The CRS Regional Health Advisor met with the Provincial and District heads and stated she was “amazed at the good relationship between the administration and the project leadership team. The level of communication is impressive, and everyone seems to be very relaxed together. The project staff has no difficulties discussing the problems the project is having, including how the MOH was failing in meeting their end of the agreement in a specific area (the MOH requested CRS to train a specific health facility worker and after he was trained the MOH never appointed him to the VCT site he was trained to work in).”

Each quarter, the extension workers agree with the CHWs on the health education topics to be given to community members during the following three months. They have a roster so that each CHW knows what topic is to be covered within that particular month. CHWs are attached to specific health facilities, and the health facility staff also provide support for the CHWs. The extension workers in coordination with the health facility staff keep track of each CHW attached to that facility to make sure that the topics have been covered, and this will assist with sustainability after the project ends.

The MCSP is strengthening the community through the CHWs, the DHCs and the CFs of the MTMSGs. During the MTE, FGD with the DHCs revealed the following:

The goal of the project is to strengthen the management capacity of the DHC to promote child survival interventions. The objectives include:

**1. To improve the DHC ability to identify the underlying factors that influence health and development.**

*This objective was met as the committees are involved in activities such as malaria prevention through promotion and utilization of ITNs, health education on environmental*

*hygiene and ensuring that breeding sites are removed, and supporting the CHWs in their monthly GM sessions, as well as many other activities.*

**2. To improve DHC interpretation of how health, development and child survival inter-relate to influence child health and development.**

**3. To acquire an appreciation for a self-reliant based approach suggested for use in the process of identifying and solving community health problems.**

*The above two objectives have been met. The community response to the committees is very positive and the committee is also able to maintain the health facility in terms of infrastructure and other logistics such as collection of drugs from the district HQ to the facility.*

**4. To identify how best to address the cultural values, beliefs, and misconceptions that influence child growth, health and development.**

*This objective is being met as some harmful habits have now been stopped by the community. Children now are being given fruits in sickness and in health, where before it was thought that fruits caused malaria. However, now the community knows the cause of malaria. EBF is now being practiced. Improvements in sanitary disposal through the digging of pit latrines is occurring. Misconceptions about vaccines and also some religious beliefs which led to children not being immunized have been corrected.*

**5. To gain the required skills to mobilize and support community participation in health, development and child survival interventions.**

*The DHC committees are involved in bridging the community with the facility staff and vice versa. They also market the health facilities to enhance utilization. For example, sign boards have now been put up at several of the health facilities.*

**6. To acquire leadership skills for advocating and strengthening community participation in health, development and child survival activities.**

*The DHCs appreciate the knowledge they have gained from the trainings offered by both the MOH and the MCSP, and they are putting this information into practice by managing the health facilities.*

**7. To understand their roles and responsibilities in the health facility management.**

*The DHCs are able to handle issues more efficiently after the trainings, esp. health facility maintenance, financial management, facility marketing and voicing community problems to the MOH.*

In conclusion, the MTE FGD demonstrated that the DHCs are now knowledgeable and are putting their new knowledge into practice, thus confirming that the trainings have been effective and the goal achieved. It was also recommended that there is a need for retraining of DHCs, as new members continue to join on an annual basis when each member is either re-elected or replaced since they serve three year terms.

The CHW and DHC are being used as linkages between the facilities and communities, as are mobile clinics for VCT/MPTCT and GM sites. Strengthening of the health facility staff is being done through training, supportive supervision, exchange visits, and provision of logistics, e.g. VCT/PMTCT. These activities have been very effective and the health facility staff have demonstrated considerable professionalism in their work on both VCT/PMTCT and IMCI. During the MTE, this was validated using tools that are valid and appropriate including the IMCI supervisory checklists, observation checklists, and the health facility assessment tool. The assessments have been used to improve health care provider practices wherever weaknesses have been identified. The results of the assessments have also been used by the MOH to make staffing changes and to post additional staff where necessary. Joint project planning between the MCSP staff and the health facility staff has improved the quality of care

over time, and facilitated a smooth working relationship. Supportive supervision, training, capacity building, and regular meetings have also contributed to the project's successes.

Training was planned and implemented as per the work plan for all project intervention areas and activities, and is considered effective based on the results of the MTE. As per the IMCI follow up and HFA report, there was evidence that there is increased knowledge and skills among the health facility staff, the CHWs, the DHCs and the caretakers as per the FGD during the MTE.

#### **d. Sustainability Strategy**

The MCSP has been closely collaborating with the MOH and communities since the inception of the project. With the MOH, the approach to sustain the project activities included working with the MOH to ensure that the necessary staff are in place to make each health facility fully functional, and to train these health facility staff members to provide a high quality of care that will lead to increased utilization by community members. The strengthening of the dispensary health committees was also designed to equip them with the management tools necessary for making sure that the facilities are in good working order and are operating according to MOH standards. The DHCs have also been strengthened to liaise between the community and the health facilities in order to manage conflict resolution and to increase utilization. Community own resource persons (CORPS) have been included in the project since the beginning, as they are the most critical component for behavior change at the household level. They have been formed into groups of CHWs and MTMSGs led by CFs, and trained to function in their roles providing health education, social mobilization and referrals. A mechanism has been established to continually provide them with the logistical and supervisory support they need to do their volunteer work well, especially after the project ends. The MOH has been very involved in working with these CORPS, and each community volunteer has been linked to a health facility for "attachment", which means that they are connected to the staff at that facility for training, logistical support and supervision.

Notable examples include the establishment of 72 GM sites which are operated on a monthly basis in each area by trained CHWs, health facility staff being trained and are functioning effectively on IMCI, VCT and PMTCT as monitored through the MIS/HIS.

The initiation of C-IMCI activities has also begun at both the community and facility levels, however the bulk of the training and implementation for C-IMCI will be accomplished during the second half of the project.

During the MTE, FGD were conducted with caretakers and CHWs, and their discussion included the following accounts: They have formed self-help groups, registered these groups with the Ministry of Culture and Social Services, opened bank accounts, and written proposals to obtain funding for their health activities. They also stated attending monthly meetings at the health facilities where they are doing their attachment after being trained. It was recommended that CFs be considered just like the CHWs in the project and included in the provision of transportation reimbursement and promotional materials.

During the MTE, a meeting was held with the PHMT where they stated, "In terms of sustainability, we don't see the project activities coming to an end. We have global funds, the EU is providing money, and we have MOH money. IMCI is an MOH strategy, so it will

continue. There is a supplementary drug kit for IMCI and HIV/AIDS coming to the province through the MOH. We are also doing cost-sharing through the facility improvement fund from the MOH. Once we have the capacity, sustainability won't be a problem. We have a good foundation now, so we can continue. Routine supervision is not a problem at the provincial level, however the districts have trouble with transportation for supervision. On behalf of the MOH, we have received a lot of support from the Division of Child Health in the MOH. We always have people from the Ministry of Health attending our trainings." The PHMT have also come on board during supervision.

During the MTE, discussions were held with the District Health Management Team, and the newly appointed District Medical Officer of Health. While the MCSP is working closely with several members of the DHMT, it seems that information sharing needs to be improved between the DHMT members because during the discussion several members who have not been actively engaged in all MCSP activities complained that they were not informed about the project goal, objectives or activities, and that the project "needs to involve the whole district health management team on the entire project".

The MTE facilitator was quite surprised to hear the DHMT making these statements as all other discussions taking place regarding the project and the partners seemed very positive, participatory and transparent. Upon further investigation, it was learned through meeting minutes that several of the members of the DHMT who attended this meeting have in fact been present at a number of meetings with the MCSP, and have also participated in trainings on IMCI, VCT/PMTCT, and MIS/HIS. The DHMT also has as part of its membership two professionals working exclusively on IMCI, and those two people were not present in this meeting, but are working extremely closely with the project on a daily basis, and they also work directly with the IMCI professionals at the provincial and national levels on a regular basis. It seems, however, that they are not sharing this information with the rest of the DHMT on a regular basis, and it was learned that there is a sort of "turf war" going on within the DHMT, so information goes directly to the MOH in Nairobi but bypasses many of the members of the DHMT. The same situation exists for the DPHN professional who is working closely with the project on VCT/PMTCT, and another DHMT professional working malaria, but both were not at this meeting. Lastly, one member of the DHMT was on the midterm evaluation team with us during the entire evaluation, but he also was not present at this meeting. It was also learned, through meeting minutes that the project had met with the newly appointed DMO several times since his appointment a few months ago.

When asked if the DHMT had copies of the quarterly reports for the project, a folder was brought out from a file cabinet, but the members of the DHMT around the table had not read it or known of its existence. Only the newly appointed DMO was aware of the reports.

In fact, the project is working very closely with at least five members of the DHMT, but the information is not being shared with the remaining members of the DHMT. Therefore, while it is not the direct responsibility of the MCSP to strengthen the internal management capacity of the DHMT, it seems that it would be in their best interest to do so, at least in terms of communication, since it seems to be the biggest problem. Some sort of intervention on increasing communication BETWEEN DHMT members could be extremely helpful for sustainability of project activities and the uptake and ownership of IMCI and VCT/PMTCT activities in the district by the entire DHMT. This is especially important because the members of the DHMT who are working closely with the project could be moved out of the

district at any time and the institutional memory within the DHMT could be lost, as well as the close relationship that the project currently has with the DHMT, albeit only through a select number of professionals on the DHMT.

*Recommendation*

The project may wish to consider developing an intervention that would increase communication between DHMT members, perhaps through management training of the newly appointed DMO.

In terms of progress made on the monitoring indicators, the project has developed a set of data collection tools which are being used by the CHWs to report their activities on a monthly basis to the extension workers, who in turn report to the assistant coordinators on their growth monitoring summary, supervisory checklist for CHWs and CFs, C-IMCI summary, breastfeeding summary, community health education summary, CIMCI supervisory checklist, CHW assessment analysis sheet, and ITN tracking sheet. The health facility staff trained on IMCI have been followed up and proved to be performing well, as documented in the HFA.

The project got off to a little bit of a slow start due to the high level of staff turnover during the first half of the life of the project. Despite this setback, the project was able to accomplish all its activities and excel in most. However, the phase out strategy and activities have not been a focus yet, and are now planned to be undertaken during the next year of the project. The MOH and the project have a clear understanding that the program runs for five years and an MOU to this effect has been signed by the two parties. The project services at the health facility level will continue as usual since the salaried MOH workers will continue serving the community members.

The project staff are aware of the project phase out, however work will need to be done with the communities to ensure that everyone is clear on the timeline, and on what activities will be continued after the project ends. The extension workers stated, “we are working in the communities to help them change their behavior for their health by facilitating the project activities. As for the training of the CHWs, we work together with the MOH staff in the project area. The reason we work together is to familiarize the CHWs with the MOH so they can continue after the project ends.”

However, the extension workers stated that, “the issue of volunteerism by CHWs has been very challenging despite the fact that we did the community mobilization and sensitization. Some of them continue to feel the need for cash payment to do their work. This is probably because in the past there were other organizations which were providing cash in every meeting they held, calling it a “sitting allowance”.”

At the community level, many CORPS have been formed, organization and trained, and are working well. CHWs have formed autonomous groups which are registered with the Ministry of Culture and Social Affairs, and they have opened bank accounts as financial collateral. Some of the groups have joined micro-financing institutions, e. g. some CHWs are now contributing money to “MBEU” a DOE micro-finance program. The CHW groups have written budget proposals to the Constituency Aids Committee (CAC) and also to the Constituency Development Fund (CDF) to solicit funds.

The DOE staff have been trained on proposal writing and fundraising strategies and skills, and will all be very marketable after the project ends, as has already been demonstrated through the high staff turnover and several staff members moving to higher paying positions with USAID and other organizations working in Kenya.

The activities for IMCI in Mbeere are being expanded and scaled up to the entire province. The province has opened two additional VCT sites outside of Mbeere but in the province. The Minister of Health has completed the new strategic plan 2005-2010 which identifies six areas that will all be addressed at the community level, as well as facility based care. It includes promotion of health seeking behavior across the country and all health sectors. The focus is also on prevention in order to decrease the morbidity and mortality in the country.

During the MTE, a meeting was held with the PHMT where it was stated, “in a different area of the country, the MOH came and dug pit latrines for the people. When they went back to see how the community was using the latrines, the people said those were the MOH latrines, but they haven’t come back to use them! ☺ It’s important that we have ownership over the IMCI activities in our province so we can maintain and grow them over time.”

### **3. Additional Information Requested**

The information listed in this section has been requested by the CSHGP through an email memorandum from Susan Youll for all 2005 program mid-term reports.

#### **a. Contribution to Scale/Scaling Up, Widespread Development of Innovative Approaches, AND Visibility and Recognition of the Project and PVO Grantee (combined)**

CRS Kenya has taken the lead in piloting the home management component of C-IMCI by training CHWs through the use of the C-IMCI training module developed by CRS headquarters. CRS Kenya and the DCH/MOH reviewed and pre-tested the module, and then translated it into three local languages (Kikamba, Kimbeere and Luo) which combined, constitute around 40% of the Kenyan population. The DCH/MOH then requested that CRS allow them to roll out the module to all parts of the country as the national training module on C-IMCI home management by CHWs. Of course, CRS was delighted and granted permission to the MOH. CRS Kenya’s Health Trainer was requested by the DCH/MOH to attend the recent WHO AFRO IMCI meeting held in Congo, Brazzaville, where they were presenting both the CRS MCSP and Suba Child Survival Projects as representations of what Kenya is currently doing in IMCI.

CRS Kenya is piloting two new strategies on community training for nutrition by CHWs using nutrition counseling cards adapted from BASICS. These cards have been adapted to each of the two CRS child survival projects in Kenya, taking into account the local situation including locally available foods.

Another innovative approach being tested by CRS Kenya is the formation of mother-to-mother support groups (MTMSG) using training tools adapted from LINKAGES. Here, positive deviant mothers (on breastfeeding) are trained as community facilitators (CF) who then lead the MTMSG acting as role models for infant feeding practices. The national MOH five-year strategic plan includes strengthened community nutrition as one of its major



components. Both regional (AFRO) and Kenya WHO Offices and the MOH have requested CRS Kenya to support the roll-out of the strategy by first building the capacity of MOH staff to be in the position of initiating community nutrition counseling, as well as forming breastfeeding MTMSG. In response to this request, CRS has provided training on C-IMCI, MTMSG and nutrition counseling cards for some MOH staff in Mbeere, Suba and Tana River Districts, and the Nutrition Division of the DCH/MOH at the national level.

Lastly, the VCT/PMTCT sites established by the MCSP have proven to be quite innovative. They are the first testing sites to be developed in Mbeere District, and are the model being used for scale up to the entire province. CRS and the MCSP project staff are also actively engaged in discussions with the DCH/MOH on national policy and scale up of VCT/PMTCT activities throughout Kenya.

The CRS Program Manager has spent a lot of time working at the national level registering the two new MOH VCT/PMTCT sites and being involved in policy discussions to advocate for HIV/AIDS at the VCT/PMTCT and Reproductive Tract Infection (RTI)/STI technical working group.

The PHMT selected one of the VCT/PMTCT sites as the BEST VCT site in Mbeere Province, and has forwarded this nomination to the NASCOP for national recognition.

## **b. Civil Society Development**

During the MTE, FGD were conducted with caretakers and CHWs, and their discussion included the following accounts: They have formed self-help groups, registered these groups with the Ministry of Culture and Social Services, opened bank accounts, and written proposals to obtain funding for their health activities. The establishment of these civil society grassroots groups is a wonderful example of the potential for communities to organize themselves and become powerful advocates for their own development.

## **c. Equity**

MTE data provided information on increased access to and utilization of PMTCT and VCT services and GM sites in the project area, thereby providing all community members equal access to these services.

The project is also considering how to establish a mechanism to ensure that “destitute” families who can not possibly pay for ITNs will receive them free of charge.

## C. Program Management

This section provides an overall discussion of program management issues, at HQ, within the field program, with partners and with the community. An assessment of the strengths and weaknesses of the management support systems, i.e., planning, financial management, information management, personnel management, supervision, training, and logistics are detailed below, along with recommendations on how these systems can function more effectively.

### 1. Planning

The MCSP does annual planning based on the work plan in the DIP. Each year, the DOE partner staff has a one-week planning meeting where they develop the work plan and budget for the following year. After they have completed this activity, they then meet with CRS to fine tune the work plan for the MCSP and for the other joint programs they are doing with CRS. It was reported that not all extension workers are included in this meeting with CRS, although they would like to be. Following this meeting, quarterly work plans are developed, and meetings are held on a weekly, monthly and quarterly basis to ensure that activities are on schedule.

During the MTE, the extension workers complained that they are not routinely included in the planning process for the project and yet they are implementing the activities on the ground with the community. They stated, “We are never given the quarterly reports, even though we are the ones providing all the data for them. We have no access to budgetary information and we are not involved in budgeting and planning activities, and yet we are the implementers. We have tried to address these issues at the monthly meetings with the project management, but decisions are already made without our input and we are simply told about them after the fact. They listen and respond, but results are slow or not visible at all. We just feel apathetic now.”

However, the management team stated that the extension workers are included in monthly and quarterly meetings, and program reviews. Therefore, it seems that there is a gap in communication and possibly perspective with regards to their involvement in the planning process. The extension workers are all qualified, educated professionals who are very capable of fully participating in program planning activities.

#### *Recommendation*

Further discussion needs to be carried out on the issue of team communication to ensure that all members of the project feel they are included in the participatory planning process.

#### *Recommendation*

The entire project team (CRS, DOE and MOH) should participate in all planning, implementation and evaluation meetings and activities for the final two years of the project in order to increase the capacity of all project partners and to ensure full ownership by the MOH staff for sustainability of activities after the project ends.

While there were initial delays in the implementation of the activities in the DIP due to high staff turnover, the project is now fully on schedule and is achieving tremendous gains in all their activities.

All members of the project team have copies of the DIP, including the monitoring and evaluation plan, and are well acquainted with the project objectives. Even the newly hired staff fully understand the objectives of the program and were able to recite the indicators verbatim, which was very impressive. For detailed information on the use of data for monitoring and program decision-making, please see the section below on information management.

During the focus group discussions in the MTE, caretakers and CHWs were able to list the objectives and/or activities of the MCSP, however some community groups were not aware of the end date for the project.

#### *Recommendation*

The project staff needs to ensure that the communities they are working with are fully aware of the project timeline and the phase-out strategy.

There was some confusion with the District Health Management Team who stated they were not aware of the project objectives and activities happening in their areas. However, upon further investigation it was demonstrated that the DHMT had been included in a number of previous briefings and trainings, that the quarterly project reports were all present in the DHMT office, and that two members of the DHMT are routinely involved in weekly activities on the ground. It was impressive that a member of the DHMT fully participated in the entire MTE. The MCSP may wish to use this opportunity to carry out additional capacity building of the DHMT in terms of communication and information management.

## **2. Staff Training**

Training of project staff has been one of the major project activities to date. Staff have been trained on VCT, PMTCT, IMCI, and all other project activities. Staff have also received training on HIS/MIS, and been involved in the pre-testing and finalization process for the monitoring tools for the project. Supervisory follow up is done after every single training for all project staff. Staff training is a large component of the capacity building plan for the project. Professional updates are continuously being carried out. See the work plan for a detailed list of all trainings that were scheduled, as all of them have been completed. Quality assurance checklists are used to assess the performance of project staff. Participatory training methods using standard guidelines for all technical trainings are carried out. Staff training on the following areas need to be done and will be completed over the next year of the project: ART provision and CHW home based care, LQAS, computer literacy (windows, Word, Excel, Microsoft Project, and EPI Info/SPSS), community dialogue tool on C-IMCI, and project management for the project coordinator and the two assistant coordinators. Exchange visits have already taken place with World Vision and another CRS child survival project, and two more visits are scheduled with the PLAN Child Survival Project in Kalifi and a CDC project on PMTCT/VCT. Adequate resources are being provided for staff training and follow up.

### **3. Supervision of Program Staff**

The project team consists of the CRS program manager and the DOE implementing field staff including the project coordinator, two assistant project coordinators and ten extension workers who work with the MOH staff and community groups to implement the project activities. Additional CRS staff include an M & E officer, a Health Education officer and other CRS management staff. Additional DOE staff include an M & E officer, a finance officer, and the Development Coordinator.

The CRS project manager works directly with the DOE project coordinator by providing technical oversight. The project coordinator supervises the two assistant project coordinators who each cover one division and supervise five extension workers. The extension workers facilitate the monthly training and health education of the CHWs and the CFs for the MTMSGs. They also work with the health facility staff on IMCI and VCT/PMTCT.

This cascade approach works well within the project due to the strong team approach, participatory management style, and regular supportive supervision at all levels.

Technical support is provided by CRS for all project partners, while supervision of project staff is carried out by the DOE directly.

Within CRS, the program manager meets on a weekly basis with his direct supervisor to provide a briefing on the activities for the coming week, and also asks for assistance where necessary when issues arise. The supervisor then briefs the Health Unit manager weekly on the project activities. The entire Health Unit meets together monthly to discuss achievements, issues that arise and how best to address them, as well as work planning for the coming month. Every other month, the Health Unit meets with all the other units in a large division meeting where overall program integration is discussed and activities planned. Both the supervisor and unit manager travel to the MCSP project area quarterly for an assessment visit.

In CRS, project staff each develop a set of objectives for their annual work plan. Quarterly they meet with their supervisors for a coaching session to review the objectives and work plan, and to monitor what has been achieved, what has not been achieved, why, and how best to proceed in the coming quarter. A new quarterly work plan is developed and lessons learned from the previous quarter are incorporated. The staff also participate in an annual appraisal using an evaluation tool that looks at the staff member's individual set objects (results based objectives). The staff member first evaluates him/her self, and then their supervisor evaluates them.

The MCSP CRS staff reported feeling comfortable with this process, stating that it helps them organize their work on a regular basis and solve problems as they arise. The MCSP program manager stated that he receives a lot of support within CRS, and that his supervisors are very involved and knowledgeable regarding program implementation, challenges and successes. The MTE consultant also found this to be true.

In the DOE, the situation is different from that of CRS. While policies and procedures are in place within the DOE, they have not been routinely followed. It is the responsibility of the project coordinator to appraise the project staff, with the assistant coordinators playing a key

role in evaluating the extension workers under their supervision as they are most familiar with their performance. While this responsibility is in their job description, this has not been followed in the past. There has previously been no annual set time for these performance evaluations to take place. During the MTE, staff complained that in the past two years they had not participated in annual reviews or received incremental salary raises, as budgeted for in the DIP.

It is unclear how the Development Coordinator directly supervises the project staff, as experienced during the MTE, the project coordinator was removed from the data collection activities in the field and sent to Nairobi to coordinate logistics and administrative issues, as his signature was required to facilitate these activities. This presented a problem for the data collection teams as his participation had been anticipated, and as he is the head of the project his absence was very noticeable.

*Recommendation*

The DOE should review its administrative policies and procedures, and provide additional administrative support to the project as necessary in the remaining two years. This activity should also be reflected in the annual budget as required.

There is an indication that additional responsibility and accountability need to be given to the project coordinator during the final two years of the project as this will increase the capacity of the project staff to learn and grow professionally so that they may fully finish implementing the project activities without delay, as well as position themselves for future employment after this project ends.

*Recommendation*

Additional responsibility and accountability need to be given to the project coordinator during the final two years of the project.

Field visits are coordinated during the week to provide supportive supervision and weekly meetings take place between the assistant coordinators and their five extension workers for team building and project implementation management. The extension workers stated that this supportive supervision is very effective, and while they all work very closely together collaborating with each other during field activities, they also have a strong relationship with their assistant coordinator who provides constant feedback and support. The two assistant coordinators also meet weekly with the project coordinator, who also assists them in their field work and provides ongoing technical and management support as necessary. All of the project staff eagerly discussed their good collaboration and team spirit.

With a new project coordinator in place, who previously was himself an assistant project coordinator, it seems that things have begun to shift in a more positive direction. There is also a relatively new assistant coordinator in place who previously was an extension worker. Thus the standing project management team has come up through the ranks of the project and therefore has a clear understanding as well as personal experience in the various staff positions, which helps them execute strong and equitable project management efficiently.

#### **4. Human Resources and Staff Management**

The CRS Program Manager plans, monitors and evaluates the activities that are being done by the project partners. He mentors the partner staff on technical issues, taking into account MOH policies. He represents CRS at the national level at partners meetings, and collaborates with other stakeholders at the national level concerning child health. Throughout the MTE, he demonstrated strong technical and management skills.

He oversees the funding of the project, the financial issues, the budget, the expenses, and ensures that they are appropriate. Liquidation is done monthly, and the DOE sends monthly expense reports which are reviewed by CRS.

The program manager used the annual work plan to develop quarterly work plans. Monthly plans are then drafted to assess what needs to be done each week.

During the first and second years, the program manager visited the field monthly. The third year he gave more responsibility to the project coordinator, and now does bi-monthly field visits (every other month to one of the two divisions) instead. He goes for one week, and decides his objectives a week in advance. When he arrives he meets with the PMO and the DMOH at least once during the week, and sometimes they join him to visit a site and address an issue. When he arrives at the project he sits down with the project coordinator and the assistants and they discuss the field objectives. Then they visit sites using a supervisory checklist to assess the various activities jointly. Before leaving the field, a meeting is held with the entire field staff and discussion and suggestions are shared based on what was learned during the supervisory visit. The program manager then meets with the Development Coordinator (in the presence of the coordinator and the two assistants) to debrief him, and discuss any issues that need his attention.

Quarterly Meetings: These meetings take place after the program manager has reviewed the previous quarterly report and provided feedback/comments to the staff. All project staff are included, even drivers. The program manager chairs the meeting. A secretary is elected each time to draft the minutes, which are then shared with the Development Coordinator, who occasionally attends these meetings. The meetings are participatory. The meeting takes an entire morning. There is an annual work plan, broken down into quarterly plans. First they review the previous quarterly meeting minutes, see what was addressed, what wasn't, and see what was done against what was planned. This is done by the assistant coordinator and then the staff under them (extension workers and drivers) fill in the gaps as per their area of supervision. Then they discuss the strengths that helped them to achieve whatever they achieved, then challenges and constraints that were met, then lessons learned on what was or was not achieved. This process helps them to address the next quarter, and to include the activities that were not completed during the last quarter. They assign an individual to be accountable for following up on various issues that arise. The program manager then shares the quarterly meeting minutes with his supervisor, the CRS Division Director, and the CRS Regional Health Advisor.

*Recommendation*

Quarterly meetings should use a standard agenda that includes a review of the project data, both for the quarter and cumulatively so that staff can observe trends over time, both upward and downward.

This could be done using graphs or charts that would provide a visual display of data for discussion and decision making.

There are weekly team building meetings held by the assistant coordinator and their staff in each division. When the program manager is in the field, he also is invited to attend. Minutes are drafted for each meeting.

Monthly Meetings: The project coordinator holds monthly program meetings with the program staff on the ground excluding CRS staff, including the accountant, two assistant coordinators, the drivers and the extension workers. A volunteer takes minutes and acts as secretary for each meeting, alternating between the two divisions each month so it is fair. A review of the activities for the previous month is done, and next steps for the following month and quarter are planned. The individual extension workers report their monthly activities during this meeting as well. They discuss their successes and challenges, and raise any issues that they need assistance to deal with. A copy of the minutes is given to the development coordinator after each meeting.

*Recommendation*

Monthly meetings should follow a standard agenda that includes a review of the project data, both for the month and cumulatively so the staff can observe trends over time, both upward and downward.

This could be done using graphs or charts that would provide a visual display of data for discussion and decision making.

While no standing meeting is set between the CRS program manager and the DOE project coordinator, they meet whenever issues arise, whenever the program manager is in the field, and otherwise communicate at least weekly by phone.

During the MTE, the CRS M & E Officer was interviewed, and she stated, "I am the second person to hold this position since the project started. However, we need to increase the time I am budgeted for on this project from 30% to 50% time due to the M & E needs of the program. We still need to establish a database, do LQAS on an annual basis as per the DIP, continue building the capacity of the project partners (DOE and MOH) in data management and use for analysis and decision making, and carry out monitoring and evaluation of the project ourselves. The 30% time I am currently allotted on this project just is not enough."

The CRS Health Education Trainer is currently spending nearly 50% of his time on this project, however his position was never budgeted for in the MCSP, so this situation needs to change and he needs to be included in the budget.

The DOE needs to add an administrative position at 25% time for the project due to the heavy administrative tasks for the project and the need for the project coordinator to be involved in more of the technical field activities. The DOE is currently donating part of the

administrative time from one of their staff members, however this needs to be agreed with CRS and added to the MCSP budget.

CRS' M&E officer has 30% of her time allocated to the MCSP. It is recommended to review in light of current program activities the adequacy of this time-allocation, and possibly increase it to 50%.

*Recommendation*

Positions and time allocations need to be added to the project budget as necessary to reflect the actual inputs and expenditures for the program.

The DOE Development Coordinator is allocated 10% time on the project. However, essential functions for project management are not being carried out in a timely manner, including financial management, and this is negatively impacting project implementation and needs to be corrected, as discussed with project staff during the MTE.

All key personnel policies and procedures and job descriptions are in place for all positions in CRS and in the DOE, however, during the MTE it was reported that they are not always followed by the DOE. Some project staff stated, "There is no equal chance or equity in opportunities. There is no fair promotion process, for instance one extension worker was simply picked and promoted to an assistant coordinator, and the decision wasn't based on merit or experience, since some of us have been here much longer. It also didn't give the rest of us a chance to even apply for this promotion." This was later confirmed through interviews with the DOE management staff.

Despite these issues, the project team is remarkably cohesive, loyal and energetic. They reported that, "The exposure to the Suba Child Survival program really motivated us and was a great learning experience and we were able to replicate some of the lessons learned from there. The exposure visits of CHWs to other supervisory areas within the project was educating and motivating for them. They are implementing what they have seen from the other areas."

The level of staff turnover has caused considerable frustration at all levels within the project during the last 2 ½ years. CRS has lost their two M&E Officers both to USAID where higher salaries are paid. The DOE has lost the MCSP Project Coordinator, two of the Assistant Project Coordinators, and four extension workers.

CRS facilitates the recruitment of senior technical partner staff including the project coordinator and the two project assistant coordinators.

During the MTE, project staff stated, "When the program started, the government wasn't employing people, but now they are, and staff turnover in the health facilities caused a lot of problems in the beginning of the program. We train people, and then they leave."

During the MTE, the project team stated that there are significant management issues within the DOE that are negatively impacting project implementation, and since CRS only plays an advisory role, they do not have direct oversight to manage these issues.



These issues include low staff salaries, non-competitive hiring practices and inefficient financial management (discussed in the financial management section below).

*Recommendation*

A review of the management and staff issues that are negatively impacting the project needs to be discussed between CRS and the DOE management teams.

While the DIP budget includes annual incremental salary increases, these have not been extended to the implementing partner project staff. This issue has caused considerable lack of morale among the project staff leading to problems with recruitment and retention. The loss of key personnel caused delays in project implementation during the first half of the life of the project. It is a tribute to the remaining and new staff that the project has been able to not only catch up with the activities that were lagging, but also excel with the remaining activities on the project work plan.

To help staff transition to other positions after the end of the MCSP, the project is building the capacity of the staff, but this is also why they are leaving for higher paying jobs, even now prior to the end of the project. During the MTE it was reported that two M&E CRS staff have moved to USAID since the beginning of the project. Others have also left for increased salaries with other institutions. The rest are highly marketable and will not have any trouble finding additional employment once the project ends.

## **5. Financial Management**

During the MTE, the issue of financial management was discussed with CRS and DOE staff. The DOE stated that quarterly financial support from CRS needs to be released in a more timely fashion as it is delaying staff salary payments and other project activities. However, upon further investigation it became apparent that this was not the case, and that CRS is strictly following their financial management protocol, and that funds are being released and liquidations are occurring as required, as stated below. It was learned that within the DOE there are some “serious problems with financial management and project cash flow”, as stated by DOE staff, and that these administrative issues are slowing down program implementation and causing long delays in payment of staff salaries, leading to a decrease in staff morale.

The MCSP project coordinator reported that, “the process of getting funds from the DOE is cumbersome and needs to be improved. It is slowing down project activities, and causing staff great financial distress as they must use their own money to pay for project activities and wait for reimbursement. When I make a payment request it is given to the accountant who gives it to the senior accountant for verification, and then it goes to the development coordinator for approval, and then back to the accountant for a check to be written, which is then sent back to the development coordinator through the senior accountant for the first signature. Then the check has to be taken to the bishop for a second signature. If any one of these people is not available it delays the process, and payments are not received on time.”

The program manager stated that liquidations of cash flow from DOE back to CRS was a problem initially, however this situation has been improved over the last year after the addition of a DOE finance officer was hired at 50% time. However, it was reported that he is

only employed part time and the DOE is now using him for other activities for part of his time, and this is unfair to the program staff who need him to be working on the MCSP as budgeted.

During the MTE, it was reported that the program manager does a budget comparison at least monthly after every liquidation by the partner, and this process informs him on the financial status of each line item, and if there is a line item being underused or overused then he can address it directly with the partner. Also it helps with evaluating the posting of the expenditures against both the CRS and USAID contributions to the project. Overall, it allows an assessment of program implementation against overall expenditures and budgets.

While a cost of living adjustment has been budgeted for in the MCSP budget, the DOE has not extended this incremental raise to the staff on an annual basis, and it was reported that this issue has not been addressed and needs to be reviewed on an annual basis.

Further discussion during the MTE revealed that differences in DOE salary levels exist and are causing a decrease in staff morale. These include a \$25 difference between MCSP coordinator and assistant coordinator salaries, and a larger difference of \$140 between the assistant coordinators and the extension workers. It was stated that, “this de-motivates and demoralizes the extension workers, and has led to a high level of attrition.” They feel that since they have not received regular raises and incremental salary improvements this is unfair. If a new extension worker is hired tomorrow, they will receive the same amount as those staff who have been employed with the project for the last 2 ½ years. Last month the entire staff received a 10% increase in salary. However, because this was done across the board, it continued to widen the gap between salary levels and positions. This has led to additional disgruntlement by the extension workers.”

Other problems mentioned included the extension workers not having appropriate safety equipment (helmets and riding gear) for their motorcycles, despite this issue being raised on numerous occasions during staff meetings, and the field staff having no clear information about per diems. They stated, “we are here at the MTE, but we don’t know how much we will get and when.” When in the field, extension workers use a lot of money on communication because the places they are covering are large, and this is a big challenge for them. They are not provided with phone cards and so have to use their own money to talk to each other about work. They use motorbikes, and if one breaks down in the field or gets a puncture, they have to have it repaired in the field and when they return to town, it was reported that they are not being reimbursed for these program expenses. All project staff recommended that the project establish medical insurance coverage for all MCSP staff.

Lastly, the issue of the community facilitators being volunteers like CHWs was raised, however they are not being provided with the transport reimbursement and lunch allowance that CHWs are receiving, and this is causing a decrease in the morale of these volunteers. One idea was to increase the amount to 1,500 Ksh per month for the CHWs and the CFs, however the issue of sustainability must be discussed regarding these payments, and what will inspire these volunteers to continue working after the end of the project should these financial incentives be stopped.

## **6. Logistics**

Logistical arrangements were made based on the DIP and the MOU between CRS and the project partners including the DOE and the MOH. CRS procurement procedures have been strictly followed. Procurement and distribution of equipment and supplies has gone relatively smoothly, and vehicles are available for project implementation. One additional vehicle was added to the project since they are working in two divisions and there are three management positions at the field level. Procurement of motorcycles was delayed due to the vehicle registrations at the country level, but this was eventually sorted out and now things are running smoothly. During the MTE, extension workers stated, “We have an efficient and effective transportation system helping us to move around and do all of these activities.”

ITNs are regularly procured from PSI. Salter scales and bathroom scales were purchased for the GM sites, IEC materials (tee shirts, nutrition counseling cards, posters, etc.) have all been put into place, and furnishings for the VCT/PMTCT sites have also been handled. Project office furnishings including computers and printers have been provided to the field offices.

The logistical challenges that face the remainder of the project include the need for five additional motorbikes so each extension worker has one for transportation, supervision, program implementation, the need for two more computers for the monitoring and evaluation officer and one of the assistant project coordinators, and a television/DVD and public address system (megaphone) for IEC activities.

## **7. Information Management (M & E)**

The program used LQAS as the sampling method for the KPC. The DIP states that the project will use LQAS on an annual basis as a project monitoring tool. However, this has not been done due to frequent staff turnover and delayed initiation of the HIS. The project is using quarterly census data that is generated by the CHWs. CHWs record in their CHW diary the number of children under five years in their village each month, and they contribute this data on a quarterly basis to the project HIS, which then develops a census of children under five years in the entire project area. The problem with this method is that the census data is not consistently provided, but the program activity data is. So, census data (denominator) may be up to six months behind the activity data (numerator).

This presents a problem in comparing the baseline data (LQAS) with the monitoring data (census). The project continues to have difficulty with data management due to the lack of a centralized project database where monthly data is routinely collected and analyzed. This would give the project the ability to calculate the correct numerator and denominator on a monthly basis.

During the MTE meeting with the DHMT, it was reported that the data from the health facilities involved in the project is not flowing to the district medical records unit. Although it is going from the VCT to the NASCOP (district level), the NASCOP isn't sharing the data with the medical records unit, so the official district records keeper doesn't know how many HIV + people there are. There is an IMCI tool for data collection that was developed and is being used, but the medical records unit staff stated that they were not familiar with the tool. Further to the discussion above regarding communication and information sharing within the DHMT,

this is another example of why it would be important for CRS to address this issue during the second half of the MCSP.

During the MTE, the CRS monitoring and evaluation officer stated, “The DOE partners are not “computer literate” enough on software including EXCEL and other necessary management programs. They need more training on computer programs and how to operate them and to use them for program management. The staff at the partner level are really dedicated and they respond to feedback from us really well, and provide responses and are willing to make changes accordingly.”

In May 2005, an MIS workshop was held to review the M&E plan. Information from the DIP determined when and how the data would be collected, and data collection tools were then developed and pre-tested in the field. A log frame was used, and action plans were developed.

The program manager stated, “The weakness in the system is the link between the implementing partner in terms of not having a database with all the project data at hand. It should be continuous data instead of periodic data. I’m still unclear about how to measure the 15% level of effort to HIV/AIDS.”

**Routine Reporting System:** the objective of this system is to provide information for decision-making and program planning. The system includes six data collection tools, which collect monthly information on growth monitoring, health education activities, exclusive breastfeeding, prevalence on ITN usage, G-IMCI, and community based population census focused on pregnant women, and children 0-36 months.

The system collects information from a geographical area that includes the divisions of Mwea and Gachoka. These two divisions have been divided into 10 supervisory areas for programmatic purposes, each of them covered by 10 extension officers.

The primary source of data is the caretaker of children under five years of age. The front line manager of the data is the community health worker of mother-group facilitator, who is the first contact with the client. Each community worker collects information from an average of 35 households in each village.

Division	Supervisory Area	# of CHWs
Gachoka	Mavuria	33
	Mbetisouth	28
	Kiambere/mutuovare	45
	Gicheche/Kithuthiri	40
	Kianjiru/Mbita	44
Mwea		
	Karaba	43
	Riakanan A	19
	Riakanan B	14
	Makima A	8
	Makima B	26

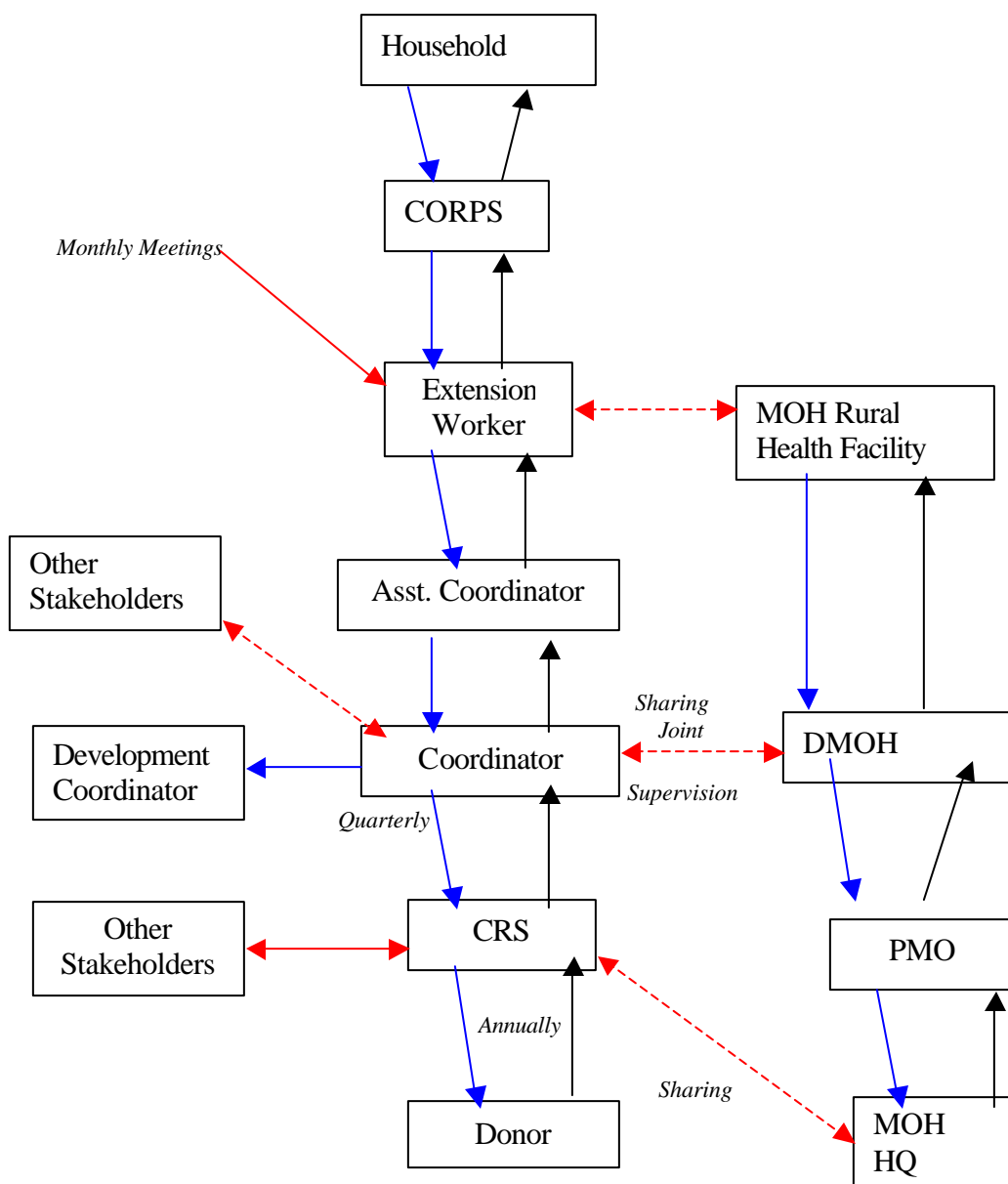
The information is collected from the client at the community level on a monthly basis by the community own resource person (CORPS) through the application of a standardized form in each village. These forms are submitted to the extension worker, who aggregates the data from all villages under its supervisory area (SA) and then fills and submits a monthly report to the assistant coordinator. The assistant coordinator aggregates all the data pertinent to its divisions and submits a report to the program coordinator. All data is aggregated and a quarterly report is then submitted to CRS Kenya office. An annual report is produced and submitted to CRS PQSD in Baltimore, which after review is then submitted to USAID

Washington. At various levels of the system information is shared systematically with the ministry of health.

## Data Analysis by Level of Data Collection

**CORPS (CHWs/group facilitators):** at this level information is used to identify undernourished children which are then selected, based on a predetermined criteria, to undergo follow up through home-visits and/or being referred to a health facility for nutritional treatment. This information is also used to infer on a causal dichotomy, nutritional deficiency and/or disease related undernourishment; this inference has implications on management decision (nutritional counseling/referral) of the undernourished child. At this level attendance to weight monitoring sessions is being monitored, as well as immunization and vitamin A coverage.

### System Information Flow:



Extension worker: at this level the information collected is being used to monitor attendance of community meetings, and thus assess the need for community mobilization activities per supervisory area. Children with severe malnutrition are identified and selected for follow up activities; distribution of vitamin A to children under five is also done based on information received from CORPS, as well as referral for immunization activities to the health center. Monitoring of home visit activities is accomplished through the information collected, as well as identification of cluster of villages with unusual levels of malnutrition. During the MTE, the extension workers stated, “We are never given the quarterly reports, even though we are the ones providing all the data for them. There are also a lot of mistakes in these reports which don’t reflect the reality of the project sites. If the reports were shared with us first, we would be able to fix some of those anomalies before the reports are finalized and sent to Nairobi.”

Assistant Coordinator: information is used to monitor levels of malnutrition per division, as well as monitoring of community attendance to growth monitoring sessions. At this level also skill performance gaps for CORPS and extension workers are identified, and recommendations and training plans are done.

M&E officers: there are two officers in the program. One is under the supervision of the program coordinator (Diocese of Embu) and allocated at 100% of its time to the project. The other is under the supervision of program manager (CRS) and allocated at 30% of its time to the project. The M&E officer at the Diocese of Embu performs on a monthly basis a comparative analysis of target accomplishments per supervisory area and per division; a quarterly report is produced as well. At the CRS end, the M&E officer receives the quarterly report and performs a comparative analysis and identification of poor performers.

Program Coordinator/Manager: information is used to identify overall programmatic and operational gaps as well as possible interventions to address these gaps.

During the MTE, each of the six data collection tools were reviewed by PQSD-STA in conjunction with CRS’ Monitoring and evaluation manager, CRS’ M&E program officer and the DOE M&E officer.

- Exclusive breastfeeding register form for community facilitator: the main objective of this form is to monitor prospectively exclusive breastfeeding prevalence amongst women participating in mother-to-mother support groups. The form has a column to annotate child’s age without explicit indication to do it by months and not by year. It would be necessary to indicate explicitly to the information recorder to annotate age in months, otherwise children 0 to 6 months of age might not be properly identified. It will also be useful to add a column or to replace the “remarks” column by a column indicating why breastfeeding was suspended.
- Breastfeeding summary report form for community facilitator: This form is suppose to aggregate information collected from mother-to-mother support groups by the exclusive breastfeeding register form for reporting purposes. The form only collects numerical quantities of total attendees, total # exclusive breastfeeding, total # on breastfeeding plus complementary feeding, and total # of expectant women. It would be useful for reporting matters to add a column for percentages to each of the three types of categories reported.

- Breastfeeding summary form for the extension worker: this form is a repetition of the breastfeeding summary report form for community facilitator. As recommended for the latter form, the same recommendation applies for this form. It is also recommended to evaluate the value added of having two almost identical forms with the HIS. It seems to me that it would be appropriate to evaluate the exclusion of the breastfeeding summary form for the community facilitator, since in addition to be a volunteer staff, it has under its responsibility the breastfeeding register form.
- Child Survival C-IMCI register: this form collects information on children under 5 years of age assessed by CHWs using the C-IMCI approach. The form lacks information on “disease outcome” therefore information on intervention impact is not collected. It is highly recommended to collect outcome information in relation to “alive” or “dead”, thus the program would be able to provide strong evidence on program impact.
- C-IMCI community summary sheets: this form will be used to aggregate data on C-IMCI disease-related interventions, specifically number of cases of pneumonia, malaria, diarrhea, and others identified, as well as number of cases referred for each of the diseases. There is a need to evaluate the value added for the “others” row in the form, and how this type of information will be used during analysis of the data. Likewise, it is highly recommended to add information of “disease outcome” and identify those cases, which die because of illness.
- Monthly VCT report form: the forms reviewed showed some flaws in the filling process, such as improper identification, addition errors, and some monthly report forms were missing such as January 2004, August 2004, November 2004, January/February/March/April 2005. The information, according to DOE’s M&E officer has been reported but on a different form.
- There are no comments for the rest of the forms utilized by the program.

Currently the MCSP is using MS-Word to keep the data, which allows for calculation errors as well as incompatibility with computer programs for statistical analysis.

*Recommendation*

Program data management should be done using Excel spread sheets.

Data analysis currently is limited to descriptive statistical analysis.

*Recommendation*

CRS’ data management level should include analytic statistical calculations in its analysis. In order to achieve this level of analysis, CRS M&E staff would need to receive appropriate training.

Quarterly reports should be standardized and include all of the project data indicators and what is being done with each one on a monthly/quarterly/cumulative basis. A copy should also be regularly sent to the PQSD.

CRS’ M&E officer has 30% of her time allocated to the MCSP. It is recommended to review in light of current program activities the adequacy of this time-allocation, and possibly increase it to 50%.

## **8. Technical and Administrative Support**

To date, external technical assistance has been provided for the following activities: breastfeeding study, World Vision exchange visit, Suba exchange visit, and AMREF and CRS trained together for VCT/PMTCT, sponsoring each others staff in trainings being done at the field level. Lastly, Dr. Sheila Macharia, USAID Technical Officer for Health conducted a monitoring visit to the project site.

The anticipated technical assistance needs of the program in the remaining life of the program include mostly training on the following areas: LQAS and database training – to be done by the CRS Regional Health Advisor, computer training to be done by a hired consultant, training on the community dialogue tool through by hiring the consultant who created the tool, and collaboration with the CRS and other agriculture programs (possibly WFP) for issues of food security.

PVO headquarters and regional support to the field project is being done by the CRS Regional Health Advisor (approximately 25%) and the PQSD at HQ in Baltimore (approximately 10%). Previously, the regional health advisor, Dr. Carmela Abate was providing a lot of assistance to the program and so the PQSD was spending less time in Kenya. However, now that she is no longer involved in program technical oversight, the PQSD will come to visit the project at least once a year, as the Program Manager stated, “I need more support from Alfonso, at least annually. It would also be helpful to have an exchange visit with another CRS child survival project outside Kenya.”

The new regional health advisor stated, “My relationship with the Program Manager is almost weekly, and he talks to me about all kinds of technical issues at any time. He sends reports, asks for suggestions, he responds to my suggestions and comments both positively and negatively and he’s always responsive even if he doesn’t agree. The exchanges between the Program Manager and the PQSD are always copied to me, and often the Program Manager sends things to me for comment before sending them to the PQSD. The CRS Kenya Community Health Unit Manager and I are constantly in contact, and all communication between me and the Program Manager is copied to the Unit Manger, who is very responsive. The communication flow among the CRS health unit flows very well.

## **9. Mission Collaboration**

To date, CRS and the MCSP have had a good working relationship with the USAID Kenya Mission. Project staff have held several meetings with Mission staff over the first half of the project including participation in the original project proposal, the DIP process, and the mid-term evaluation.

The project team as well as CRS staff sit on several national working groups and task forces that also have as their members USAID staff, including IMCI and HIV/AIDS. MCSP project reports are routinely submitted to USAID, as required under the cooperative agreement.

The program objectives for the MCSP fully compliment and contribute to the USAID Kenya Mission health objectives (SO) and results.



#### **D. Other Issues Identified by the Team**

All issues discussed with the team have been included in other sections of this report. There were no other issues identified by the team that need to be mentioned separately here.

## **E. Conclusions and Recommendations**

### **Conclusions**

Overall, the MCSP is doing very well. The project is on target with all activities, and there is considerable progress being made as demonstrated throughout the results of the MTE.

There are a few issues that will need to be addressed over the next year of the project, however these were all discussed in detail with the staff during the MTE. In fact, most of the issues were raised by the staff themselves, and the staff also came up with solutions for nearly every problem which they are facing.

The team is very strong and loyal, and there is incredible team spirit and commitment toward the project. The staff are working very hard, and have every right to be proud of their activities and the results they are achieving in Kenya.

I wish them success in the second half of their project, and there is no doubt that they will continue to produce excellent results and demonstrate impact in the communities with which they are working.

### **Recommendations**

#### **Technical**

1. The project should continue strengthening the referral system, including monitoring of the system, to ensure appropriate follow up by a skilled health provider of referred patients, and to accurately reflect CHW referrals to health facilities. The issue of counter-referrals from the health facility back to the CHW should also be explored to further improve follow up of sick children at the community level and to reinforce sustainability of the system.
2. Liaise and discuss with the CRS agriculture team and WFP regarding food security issues in the project area e.g. survey on food availability and utilization by CRS agriculture.
3. The CHW training on ORS should provide additional focus on checking package expiry dates.
4. Health education sessions on malaria need to focus on care seeking within 24 hours of fever onset, and the maintenance of bed nets once purchased (re-treatment, no holes).
5. CHWs need to be provided with additional training on ITN maintenance, including encouraging re-dipping at the household level, and ensuring that ITNs are kept clean and free of holes and tears.
6. The project may wish to consider developing special nutrition counseling cards for HIV infected women and children, due to their specific nutritional needs.

7. The project staff discussed the need to incorporate ART, deal with the issue of CD4 testing (both the broken machine and the high cost of testing), and start home-based care for HIV positive patients. Therefore, training on ART is needed for both the project staff and the health facility staff.
8. The project may wish to consider developing an intervention that would increase communication between DHMT members, perhaps through management training of the newly appointed DMO.
9. Conduct operations research to investigate the follow-up of HIV positive mothers and newborns identified through the PMTCT facility and program activities
10. Further discussion needs to be carried out on the issue of communication between the extension workers and the project management staff to ensure that all members of the project team feel they are included in the participatory planning process.
11. The entire project team (CRS, DOE and MOH) should participate in all planning, implementation and evaluation meetings and activities for the final two years of the project in order to increase the capacity of all project partners and to ensure full ownership by the MOH staff for sustainability of activities after the project ends.
12. The project should develop a database, and train staff on its use, including providing feedback on the data system to the community.
13. The project staff need to be trained on the items listed under the training section of the MTE report.
14. The project should consider a more systematic approach to analyzing and using data and information for program monitoring and decision-making.
15. The project needs to implement LQAS monitoring on an annual basis as per the DIP, or change the monitoring plan.

### **Recommendations from the Dispensary Health Committee (for MCSP consideration)**

- Enforcement of security by fencing the health facility compounds
- Provision of drugs and snake venom
- More training of DHC members
- Provision of first aid kits at schools
- Participation of DHC in MCSP from problem identification, planning, implementation and evaluation
- Certificate for DHC training
- CHWs to be issued with drugs at the village level, and follow up to be made – perhaps CRS can work with the MOH to pilot this in 1-2 areas
- Corps to be issued with identification badges
- Open VCT/PMTCT centers in other institutions
- More training for CHWs

- MCSP/CRS to start up food supplementation for malnourished children under five
- MCSP to link the CHWs to health facilities for continued support and supervision and provide funding for training on other health related interventions e.g. Ferro-cement tanks and VIP latrines
- MCSP to support health institutions with physical infrastructure construction - at least one per health facility in the project area

## **Program Management**

16. Further discussion needs to be carried out on the issue of team communication to ensure that all members of the project feel they are included in the participatory planning process.
17. The entire project team (CRS, DOE and MOH) should participate in all planning, implementation and evaluation meetings and activities for the final two years of the project in order to increase the capacity of all project partners and to ensure full ownership by the MOH staff for sustainability of activities after the project ends.
18. The project staff needs to ensure that the communities they are working with are fully aware of the project timeline and the phase-out strategy.
19. The DOE should review its administrative policies and procedures, and provide additional administrative support to the project as necessary in the remaining two years. This activity should also be reflected in the annual budget as required.
20. Additional responsibility and accountability need to be given to the project coordinator during the final two years of the project.
21. Quarterly meetings should use a standard agenda that includes a review of the project data, both for the quarter and cumulatively so that staff can observe trends over time, both upward and downward.
22. Monthly meetings should follow a standard agenda that includes a review of the project data, both for the month and cumulatively so the staff can observe trends over time, both upward and downward.
23. Positions and time allocations need to be added to the project budget as necessary to reflect the actual inputs and expenditures for the program.
24. A review of the management and staff issues that are negatively impacting the project needs to be discussed between CRS and the DOE management teams.
25. Program data management should be done using Excel spread sheets.
26. CRS' data management level should include analytic statistical calculations in its analysis. In order to achieve this level of analysis, CRS M&E staff would need to receive appropriate training.

## F. Results Highlight

The VCT/PMTCT sites established by the MCSP have proven to be quite innovative. Prior to the inception of the MCSP, there were no VCT/PMTCT services in Mbeere District, and no MOH staff trained to operate them. The CRS Program Manager has spent a lot of time working at the national level registering the two new sites and advocating at the VCT/PMTCT and Reproductive Tract Infection (RTI)/STI technical working groups. MTE data provided information on increased access to and utilization of PMTCT and VCT services in the project area. The PHMT selected one of the sites as the BEST VCT site in the province, and has forwarded this nomination to the NASCOP.

During the first half of the project, a lot of time was spent training staff and setting up the two sites. The first site, Kiritiri, opened December 1, 2003, and now operates with four VCT counselors (one trained by PLAN and three trained by CRS), and three PMTCT counselors (all trained by CRS). Initially turnout at Kiritiri was a bit low, so the project assisted the MOH in establishing mobile testing sites that do both VCT and PMTCT. At the first mobile clinic site, turnout was so large they had to turn people away. Soon after the first site, they held a second site nearby and they were able to provide services for everyone who came. The mobile clinic sites have been held in a school where there are several rooms that can be used to organize the various services. The mobile sites use the same procedures for counseling and testing as those used in the health facilities.

The second VCT/PMTCT site, Karaba, opened in April, 2004. Initially there was only one staff member trained, and so when that person would leave, the site would need to close, but now there are sufficient staff and the site is always open for services. This site reported that they saw 329 clients during the first six months of this year (male 151, female 178). However, last year many more men than women were attending the VCT services, so they did a lot more mobilization with women and now the usage by females is much better. Both sites now have PMTCT services as well. The process is similar to VCT however after women receive their routine tests for ANC, those who are willing to be tested for HIV are then taken to the PMTCT services in the clinic. Here they receive counseling and are educated on all the issues surrounding PMTCT, and then are tested.

Clients	2004	2005
Male	61%	46%
Female	39%	54%

In both sites, VCT services have been established according to national guidelines, and during the MTE health staff stated they safeguard the welfare of the VCT clients by making sure that they adhere to the code of ethics of the MOH NASCOP guidelines. Clients come in for confidential sessions where they are welcomed and made to feel comfortable. Then they are asked what has brought them in to be tested. The health care provider then contracts with the clients, which includes gaining client consent for the services and discussing issues of confidentiality. An assessment is then carried out regarding the risks that the client is taking with HIV. Information is provided on modes of transmission, and then together the client and health care provider look for options for reducing those risks. The client is then tested with two test kits for parallel sampling, which take about 15 minutes in total. A third tie-breaker test is used when the first two tests do not agree. Since starting this testing process, only two clients required tie-breakers. Finally, a post-test counseling session is conducted to encourage the client in behavior that will help them retain their negative status, or to provide information and referral for treatment for positive clients. The entire consultation takes from 45 minutes to 1 hour. A couple will take a bit longer. Follow up appointments for further counseling are also scheduled for HIV and for related health needs including nutrition, opportunistic infections, ART, etc.

## **ANNEXES**

Annex 1	Summary of Baseline Assessments from the DIP
Annex 2	Midterm Evaluation Team Members
Annex 3	Assessment Methodology
Annex 4	Tools and Responses
Annex 5	Field Work Logistics
Annex 6	Feedback with Partners after Final Presentation
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Annex 9	Project Data Sheet Form (updated)

## Annex 1

### Summary of Baseline Assessments from the DIP

The summary findings are presented in narrative and CSTS format.

#### *Sentinel Measure of Child Health and Well-being:*

1. Percentage of children age 0 – 23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population) **15.4%**

#### *Prevention of Illness/Death:*

2. Percentage of children age 0 – 23 months whose births were attended by skilled health personnel. **30.9%**
3. Percentage of mothers with children age 0 – 23 months who received at least two Tetanus Toxoid injections before the birth of their youngest child. **17.1%**
4. Percentage of children 0 – 5 months who were exclusively breastfed during the last 24 hours. **0%**
5. Percentage of children age 12 – 23 months who were fully vaccinated (against the five vaccine-preventable diseases) before the first birthday. **62.4%**
6. Percentage of children age 12 – 23 months who received a measles vaccine. **91%**
7. Percentage of children age 0 – 23 months who slept under an insecticide-treated net (in malaria risk areas) the previous night. **9.6%**
8. Percentage of mothers with children 0 – 23 months who cite at least two known ways of reducing the risk of HIV infection. **30%**
9. Percentage of mothers with children age 0 – 23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated. **0.3%**

#### *Management/Treatment of Illness:*

10. Percentage of mothers of children age 0 – 23 months who know at least two signs of childhood illness that indicate the need for treatment. **68.4%**
11. Percentage of sick children age 0 – 23 months who received increased fluids and continued feeding during an illness in the past two weeks. **7.1%**

#### *No information was collected on the following 2 indicators:*

1. Percentage of children age 0 – 23 months who were born at least 24 months after the previous surviving child.
2. Percentage of children age 6 – 9 months who received breast milk and complementary foods during the last 24 hours. (Complementary are defined as: mashed, pureed, solid, or semi-solid foods). Direct question on this was not included in the survey questionnaire.

## Annex 2

### Midterm Evaluation Team Members

*(all participants were interviewed and/or contacted)*

The following individuals participated in the midterm evaluation and many were involved in writing and/or editing the midterm evaluation report:

1. Della Dash	External Evaluator	Consultant
2. Alfonso Rosales	PQSD/Health	CRS/HQ
3. Ana Maria Ferraz de Campos	Technical Advisor, Health & HIV/AIDS	CRS/EARO
4. George Okoth	MCSP Manager	CRS/Kenya
5. Kinyanjui Kaniaru	Community Health Unit Manager	CRS/Kenya
6. Tom Oywa	Health Education Trainer	CRS/Kenya
7. Rachael Macharia	Monitoring & Evaluation Officer	CRS/Kenya
8. Gilbert Namwoja	Monitoring & Evaluation Unit Manager	CRS/Kenya
9. Hanna Dagnachew	HABN Director	CRS/Kenya
10. Ken MacLean	Country Representative	CRS/Kenya
11. Amon Njeru	District Public Health Nurse	Mbeere District, MOH
12. Jackson Mugambi	MCSP Coordinator	Diocese of Embu
13. Joan Nyambura	Assistant Coordinator	Diocese of Embu
14. Rose Njogu	Assistant Coordinator	Diocese of Embu
15. Lilian Kinyua	Monitoring & Evaluation Officer	Diocese of Embu
16. Fr. Vincent Ireri	Development Coordinator	Diocese of Embu
17. Bob Kaugi	Extension Worker	Diocese of Embu
18. Paul Muriuki	Extension Worker	Diocese of Embu
19. Joseph Kamau	Extension Worker	Diocese of Embu
20. Salesius Gitonga	Extension Worker	Diocese of Embu
21. Martha Mwangi	Extension Worker	Diocese of Embu
22. Florence Kuria	Extension Worker	Diocese of Embu
23. Domisiano Njagi	Extension Worker	Diocese of Embu
24. Virginia	Extension Worker	Diocese of Embu
25. Vincent	Extension Worker	Diocese of Embu



## **Annex 3**

### **Assessment Methodology**

The midterm evaluation was conducted using a fully participatory approach which included all project staff in the design, implementation, analysis and recommendation phases of the evaluation.

It was determined that the most effective way to evaluate the capacity of the MCSP staff to plan, implement, monitor and evaluate the program was to involve them in each of these steps and determine their strengths and weaknesses, and make recommendations on how to improve their ability to manage the challenges they will face during the second half of the life of this project.

Evaluating the processes being used to achieve the objectives set out in the DIP was the second goal of this evaluation.

The evaluation was initiated using various team building exercises and activities aimed at breaking down barriers and encouraging full and honest participation by everyone involved. There was a continuous effort to include the entire team throughout the evaluation. Initially the extension workers were not included in the MTE. However, after discussion on the first day, it was determined that their participation in all activities of the MTE was essential if the evaluation was to truly represent the entire project.

Mbeere Team Presentations: The first day the project presented their program to the group and included a map of the project area, available data to date, strengths, weaknesses, constraints and challenges, recommendations, and finally discussion was held at the end.

The following days were spent going through the DIP and the indicators one by one, and looking at the project activities and the monitoring system to evaluate what data was already available, and what data would need to be collected during the MTE. The staff then made a list of the data gaps, and then designed tools to fill those data gaps. The entire team then went to the field to pre-test those tools, and then to carry out the data collection portion of the evaluation.

The team then returned to Nairobi, collated the data, and jointly went through and analyzed all the data to mine it for hidden gems, and to see if we in fact did fill our data gaps. In the end, it was decided that the MTE had been successful on both accounts.

The final days of the evaluation were spent preparing for and holding a presentation for all stakeholders to share the MTE preliminary results and get feedback from the group.

Recommendations from the entire MTE process can be found throughout this report.

## Tools and Responses

### Dispensary Health Facility – Focus Group Guide

#### **1. Please tell me about your committee....**

##### **Composition and representation (number of participants and gender distribution, age)**

- All committees are composed of nine members, with higher number of men than women
- The committee members age ranges from 28-68 years
- Other co-opted members are public health technician working in those areas

##### **How often do you meet? Do you follow an agenda?**

- Committee meets once in a quarter but they can meet any other time when an urgent matter arises - 5
- They do have agenda to deliberate on before the meeting - 5
- The in-charge of the facility is the custodian of the minutes - 5

##### **Are the committee members getting along?**

- The committees are very intact and members appreciate one other -5

##### **Tenure of office**

- The tenure of office is 3 years - 5
- The committees were selected by the community members - 4
- Members are drawn across the villages – 5
- Appointed by the chief - 1

#### **2. Please tell me about the activities you are doing to facilitate health services in the health facility and in the community**

##### **Community:**

##### **Issues related to the community: transport, patient satisfaction, awareness rising, cost**

- We emphasis on good environmental and personal hygiene, where we teach people to put up latrines We also encourage them to compost pits -2
- Utilize our dispensary when sick instead of buying medicine from the shops -
- We inform pregnant mothers to attend antenatal clinic as well as caretakers to take child for growth monitoring
- We promote utilization of ITN, educate members to take treated or boiled water.
- We do also inform community members when the drugs are in the dispensary and when out of stock We discourage community members to avoid use of herbal medicine and to utilize health facilities instead.
- Community members use two hours one way to access to a health facility through walking and in some areas, people use hired bicycle as taxi (boda-boda) costing from 30-100 Ksh

##### **Points to address in each area above: networking, advocacy, mobilization, quality assurance and accountability**

- The committee supports the CHWs in their monthly growth monitoring sessions
- The committee also helps in the dissemination of health talk in women groups and in chiefs barasa We also advise community members to maintain the laid down protocols while sourcing for services in the dispensary
- We get information/issues from community members where we address them during our meeting forums
- We do mobilize our community members during campaigns like vitamin A, measles and polio\
- We also use village elders to disseminate information to the caretakers

##### **How have the community responded to this facilitation?**

- The community response to us is very positive. This is evidenced by the caretakers practically actualizing what we teach them. For example, the caretakers are now taking their children for GM.

##### **Health Facility:**

##### **Services: GM, Promotion of ITN, PMTCT, VCT, mobilization.**

- The facility offers the following services: curative, sales and promotion of ITN, health education, PMTCT counseling – 1
- GM, immunization, family planning, antenatal care - 5
- Managerial responsibilities: health facility maintenance, finance (revolving fund), conflict resolution (complaints), communication, marketing the health facility, drugs/stock
- Committee members make sure the health facility is repaired, painted and the entire compound is clean
- The committee sat down and looked into purchasing of laboratory equipments – 3
- The committee also facilitated transportation of drugs from district headquarters using the cost sharing funds - 5
- We employ casual laborers e.g. watchman, cleaners using cost sharing funds

- We also buy water which is ferried here using ox cart at a rate of 100 Ksh per 200 liters jerrycan or 15 Ksh for a 20 liter jerrycan
- We have also facilitated in digging of holes for planting trees in the next rainy season
- The committee handles cases which they can manage and hands over the complicated ones to the chief

**Advocacy, quality assurance, networking, accountability.**

- We act as an interface between the community members and the health facility staff
- We charge 10 Ksh for all patients above five years of age, which is receipted and at the end of the day is entered into the cash book
- The treasurer comes weekly to verify the accounts
- The committee has a bank account – 3
- Committee has a cash box for security purposes - 1
- We learn from our community members when they are satisfied with our services
- The high turnout of people utilizing our health facilities shows us we are giving quality services
- On accountability, we implement what has been passed by the sitting committee
- The executive committee meets on a monthly basis for payment of the casual laborer, which is receipted and signed that they have received payment

**Marketing the Health Facility**

- Tell people that drugs are available in the dispensary
- Discourage the community from buying medicine in the shops because they might have expired
- Tell them that we have qualified personnel in the dispensary who can identify their problems

**3. Please compare this committee before and after the training sponsored by the Catholic DOE-MCSP/MOH Facility Improvement**

- We have dug holes for planting trees during the coming rainy season
- Put up sign board
- Painted our facility
- Repaired one door and one ceiling

**Training: leadership, behavior change, management, usefulness.**

- MCSP has trained us once, while MOH has conducted several trainings
- We were taught how to manage the health facility, how to utilize funds
- The training gave us an opener on how to channel our grievances through chief baraza and other avenues
- The training improved our skills on how to perform our duties without conflict and duplication
- We are also able to link with our in-charge in our dispensaries and also ask for some logistics i.e. Attendance levels, how the facility is running, and this has really helped us a lot
- The community also become very responsive of the entire running of the dispensary
- We give health talks to the community members during chief baraza, groups, churches and also sell institutions ideas to the public

**Impact: changes in behavior and healthy life style.**

- The candid behavior change noted before training, sick children were not given fruits for this could lead to severe malaria. Now this has changed and children are given adequate fruits in health and in sickness
- Also cold water was not given to children as this could lead the child to get malaria. Now they know the cause of malaria
- EBF was not done before, but now some others are practicing
- Before community members did not know the importance of using ITNs. Now the majority have ITNs at home
- Many people are seeking health services in our health facility than before
- Health education sessions are now conducted in the community level and there is a positive change at the household level
- Community members adhere to drug compliance unlike before
- Almost all homes have latrines which is a drastic improvement and is attributed to the training of the community members
- The growth monitoring at village level has reduced distance to health facility and hence high number of attendance
- Before they were applying cow dung on BCG sites. Now they don't
- The community members had false perception on polio and measles campaign. They thought it was a way of passing the HIV/AIDS virus

**Challenges, constraints, successes, fears, motivation**

- The major challenge we are facing is financial hardship and this makes our effort to run services at the dispensary futile
- On growth monitoring site reduction by MCSP this has forced some of the caretakers not to bring their children for growth monitoring citing long distances to source available growth monitoring services
- Our dispensary lacks waiting bay for the patients
- Our storage tanks are leaking and so we don't have enough water for the dispensary needs
- Our facility lacks laboratory services and so patients walk long distances for laboratory services
- The compound is not fenced, neither do we have a gate, hence insecurity
- The facility lacks a sign board to direct patients to the dispensary
- There is no repair of staff houses and the ceiling is falling off
- The facility lacks electricity
- We at times lack funds for the payment of the casual workers
- Patients coming for health services during odd hours
- Lack of motivation i.e. dispensary health committee – lunch allowance
- Lack of fund for electricity payments
- TBAs in our villages lack identification badges for effective referral system
- We feel challenged while handling very sick patients because of lack of communication, telephone, ambulance
- Lack of water. We use donkey to draw water costing 10-15 Ksh per 20 liter jerrycan
- Lack of maternity services in our institution thus leading to many home deliveries
- On successes, it's notable to say we are very cohesive and no conflict at all
- We are appreciated by the people who selected us due to our good performance
- Reduction of mortality rate
- Reduction of malaria cases attributed to utilization of ITNs
- Change of sexual behavior hence, reduction of HIV/AIDS infection
- Good mobilization and usage of VCT/PMTCT services, hence quite a number of people seek to know their HIV status
- Promotion of gender equity, as before the community members never used to respect women in senior positions
- Has improved our health facility through renovation, painting and fencing
- Already put up a laboratory ready to function once we get a laboratory technician – 1
- One of our major fears is lack of laboratory equipment due to lack of money, and if we buy how about the security of the equipment
- Can we manage to employ a laboratory technician
- Will the community members willingly pay for the services rendered in the laboratory
- We would like to take a loan for the repair of the water tank, but we fear whether we would be able to repay the loan using the cost sharing money
- If our watchman may be attacked by thugs, whether we can be able to cover for damages
- In opening the laboratory, we feel there will be a lot of patients/clients which may compromise the quality of our services due to workload
- We fear our tank may crack down due to water shortage

**Relationships: are appreciated and supported by the community and MOH?**

- MOH has supported us in training of the DHC
- Provision of qualified personnel
- Supportive staff – 1
- Supply of drugs and equipment
- Putting up health facility structures
- Supported us in our new intervention – laboratory project
- Advises us on what to do in conflicts, and at times the MOH takes the lead in investigation and follow up
- The MOH also conducts seminars on training health workers
- The DHMT also visits the facility once per month for supervision
- In the community, the chief is very supportive of our ideas, interventions, and supports us to source money from the community neighbors
- Community members also source for health services in our dispensary
- Committee members are blessed enough with ideas they get from the community
- The community members help us with clearing our dispensary compound – 1
- The community members show positive change of behavior after giving health talk
- They also helped us in carrying sand, hardcore and in manpower when we were putting up a toilet structure – 1

- Identification and selection of DHC hence they appreciate their work as they are their own resource person

**Other relationship: what is your relationship with MCSP**

- The MCSP has supported us in training of three members of our DHC – 5
- The MCSP has supported us in training of our CHWs – 5
- Provision of growth monitoring sites within reach for the community, thus reduction of workload to our health facility and a marked increase in the number of children under five taken for growth monitoring
- Provision of ITNs within our community
- Training of our clinicians on IMCI, PMTCT/VCT and MIS/HIS
- Provision of IEC materials on HIV/AIDS and infant feeding
- Training of community facilitators
- MCSP has also brought down ORS and powertabs to our community
- Provision of vitamin A supplementation at GM site
- Setting up of two VCT sites and one PMTCT site
- Creating HIV awareness has highly been spearheaded by MCSP through GM sites and chiefs baraza
- The MCSP has facilitated health-seeking behavior as mothers are able to detect early signs of pneumonia and malaria

**Is this sustainable? Are you going to continue this job?**

- As committee members will be able to sustain what we have already started with MCSP for we will continue with health education in our communities and also safeguard the health institutions through security provision
- Will network and collaborate with CHWs and also source funds to start income generating projects which will improve the economic status of the area
- We will introduce charges in the GM site, 5 Ksh for sustainability purposes
- The health facility will buy ITN, drugs, ORS, powertabs for usage at the community level when MCSP phases out

**4. Is there anything else you would like to discuss?**

**Future Plans**

- Fencing our compound -3
- Renovation – 5
- Installation of dispensary canteen (shop) – 1
- Upgrading our dispensary to a health center - 3
- Starting a goat rearing project to source money to support our dispensary -1
- Setting up a laboratory – 3
- Buying a water pump to facilitate pumping water into the existing water tanks – 1
- Buying and stocking of anti-snake venom – 2
- Put up a farm where we will grow maize and cotton to boost income for our dispensary – 1
- Putting up a staff toilet – 1
- Put up a proposal to source money for our dispensary – 5
- Put up electricity – 2
- Put up a maternity unit – 1
- Future plan is need more staff to cater for the workload in our dispensary – 5
- To have an ambulance to facilitate the referral system – 3
- Putting up waiting bed –1
- Putting up an incinerator – 1
- Innovation of our staff houses - 1

**Recommendations**

- Enforcement of security by fencing the compound
- Provision of drugs and snake venom
- More training of DHC members where more members should be trained – 2
- Provision of first aid kits at schools
- Participation of DHC from problem identification, planning, implementation and evaluation
- Certificate for DHC training
- CHWs to be issued with drugs at the village level, and follow up to be made
- Corps to be issued with identification badges
- To open up a VCT/PMTCT center in other institutions
- More training for CHWs

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- MCSP/CRS to start up food supplementation for malnourished children under five
- MCSP to link the CHW to health facilities for continued support and supervision to be funded on health related interventions e.g. Ferro-cement tanks and VIP latrines
- MCSP to support health institutions on physical or infrastructure construction at least per very facility

### Questions

- When are you going to implement our recommendations?
- Will you give us feedback from the MTE review?
- When will MCSP phase out?
- Is there support from MCSP on nutrition supplements?
- What support will you offer to our problems/recommendations?

Thank you for your time and participation in this important program evaluation. The information you shared with us today will be compiled and shared with you at a later date. Kwaheri!

### CHWs – Focus Group Guide

DATE	FGD Site	Division	SA	Female	Male	CF	Start	End
August 2005	Kilia	MWEA	Riakanau B	3	3	2	13:15	15:00
	Nganduri	GACHOKA	Kianjiru/Mbita	6	4	1	11:02	12:48
	Mutus		Kianjuri/Mbita	2	3	1	14:30	16:10
	BI		Mavuria	5	2	1	10:45	12:15
	Makima	MWEA	Makima A	3	5	3	14:20	16:10
	5	2	4	19	17	8		

### 5. Please discuss your management skills, and the activities and issues you face

#### Logistics

The CHWs reported to have the following logistics for GM activities:

- Registers
- Tally sheets
- Salter scales
- Bathroom scales
- Transport reimbursement of 500 shillings per month 5 groups
- 5GROUPS
- ORS to give care takers 5groups
- Vitamin A supplements given at GM sites 5 groups.
- Bicycle one per supervisory area 5 groups
- ITNS and ITN Tally tracking sheets 5groups

#### Leadership skills

- Trainings by MCSP - 5
- Confidence to address people when giving health talks -3
- Net working with MOH staffs - 5
- Good relationship with the community we serve - 5
- Very good relationship and support from MCSP - 5
- The caretakers are satisfied with our services - 5
- The incidence of morbidity and mortality has gone down - 5
- Creation of awareness in the community and advocacy of MCSP interventions - 5
- Community mobilizations to adopt health-seeking behavior – 5
- We are now more accountable in our daily undertakings e.g. report writing, as treasurers and in our homes - 5
- The provincial administrators and other leaders involve us wherever they have a meeting to give health talks - 5
- In schools during parent meetings we are allowed to give health talks - 5
- Referral skills gained - 5

#### Monitoring

- Presence of kitchen gardens to provide green vegetables - 3
- Monthly meetings with all supervisory CHWs and EO to share reports - 5
- Appreciation of our work by the community - 5

- Appreciation of our work by MCSP - 5
- Collaboration, appreciation and support by the MOH staffs - 5
- Registered our group with the ministry of culture and social services - 4
- We are able to identify cases needing referral to health facility. Health seeking behavior has increased - 5
- More care takers are looking for ITNs to buy - 5
- We can give health talks on MCSP interventions very confidently – 5
- We are consulted by caretakers daily on health matters – 5
- The MOH are now getting less serious cases – 5
- Mothers are now exclusively breastfeeding - 5

#### **Motivation**

- Appreciation and recognition by mothers of children under five - 5
- Appreciation of the job by the MOH staff – 5
- Involved by the MOH staff to take student nurses for home visits – 1
- MOH staff involving CHW in home visits for follow-up – 3
- Transportation reimbursement during monthly meetings – 5
- Registration of the CHW self-help groups with the Ministry of Culture and Social Services – 5
- Opening bank accounts – 2
- Disease incidences have gone down – 5
- The proposals we are writing to ask for money to fund our activities – 2
- The good relationship with the MCSP and the MOH – 5
- The trainings we get from MCSP – 5

#### **6. How do you tell that a child has Malaria (fever) and what do you do?**

- a child will be having fever – 5
- diarrhea – 4
- vomiting – 5
- joint aches - 3
- poor appetite – 5

#### **What do you do?**

- Refer to the dispensary – 5
- Tepid sponge then refer to dispensary – 5
- Tepid sponge, give panadol, then refer to dispensary - 5

#### **Pneumonia (fast/difficult breathing)**

- Cough – 4
- Fast breathing – 5
- Difficulty breathing – 5
- Fever – 3

#### **What to do?**

- Refer urgently to the dispensary – 5
- Add extra clothing then refer urgently - 5

#### **Diarrhea (3 + loose stools in 24 hours, give ORS)**

- Prepare ORS and give to the caretaker to give the child, then refer to the dispensary – 5

#### **Discuss the referral system (including follow up)**

- When a mother brings a sick child to me, I write down the complaints from the mother on the referral note. Then I examine the child to exclude danger signs, write my findings on the same referral form, then give the referral form to the mother to take the sick child to the dispensary. After the child is treated I do a home visit to assess the progress of the child – 2
- I take history, write my findings on a piece of paper and refer the mother to the dispensary. I make follow up visits to assess progress – 3

#### **7. What are the prevention measures that you teach caregivers about:**

##### **Malaria (ITN)**

- To use ITNs – 5
- To observe environmental hygiene, drainage of stagnant water around the compound - 5

### **Pneumonia**

- During cold weather, to dress the children with extra warm clothing – 5
- To prevent children from touching cold water – 5
- To exclusively breastfeed their children – 4

### **Diarrhea (hygiene)**

- To observe environmental and personal hygiene – 5
- To cover drinking water and food – 5
- To wash hands before preparing food and before feeding a child – 5
- To boil drinking water – 4

### **HIV/AIDS (VCT/PMTCT)**

- To abstain from having multiple sexual partners – 5
- To access VCT/PMTCT services – 5
- To be faithful to one's partner – 5

### **Nutrition and micronutrients (EBF and GM)**

- To regularly weigh their children every month – 5
- That nutritious foods are available within our communities – 5
- Locally available foods are rich in vitamin A – 5
- To exclusively breastfeed – 5
- Signs and symptoms of malnutrition – 4
- How to interpret the child health card – 5
- To demonstrate locally available foods to caretakers, the balanced diet, and the classes of foods – 5

### **8. Is there anything else you would like to discuss?**

### **Challenges**

- We use a lot time in community mobilization and advocacy. If possible, increase the 500 Ksh for transport to 3,000 Ksh per month - 1
- The 500 Ksh is too little. Our spouses are telling us that we are using a lot of time on community work instead of using it on the family – 4
- The distance from one point to another, the distances are too long – 5
- More bicycles to be provided – 4
- To be provided with mobile phones to ease communication among the CHWs, and between the CHWs and the extension officers – 3
- As CFs we are doing a lot of work educating the mothers and the community on EBF, but the project has not considered us the way the CHWs as far as transportation reimbursement and tee-shirts are concerned - 5

### **Future Plans**

- To continue the activities to promote the health of the children under fives - 5
- To continue the collaborative effort with the MOH – 5
- To contribute on a monthly basis to continue our activities – 3
- To register with the Ministry of Culture and Social Services – 1
- To write proposals to fund our project activities – 4
- The CF to work more closely with the MOH - 4

### **Recommendations**

- The project to lay down systems whereby the severely under weights can be provided with highly nutritious supplements (flour) – 5
- Every CHW to be provided with a uniform and diary – 4
- To provide supplements to underweights – 5
- Transport reimbursement to be increased – 5
- More training for CFs – 2
- More bicycles to be provided - 5

### **Questions**

- Will the project provide under weights with supplements? – 5
- When will you give us the MTE feedback? - 5



Thank you for your time and participation in this important program evaluation. The information you shared with us today will be compiled and shared with you at a later date. Kwaheri!

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### Caretakers – Focus Group Guide

#### 1. How do you tell that a child has Malaria and what do you do?

- Fever 13
- Vomiting 11
- Diarrhoea 2
- Refusal to eat 13
- Shivering 11
- Sneezing 1
- Irritability 1
- Headache 3
- General malaise 3
- Running nose 6
- Yellow eyes 3
- Joint pains 4
- Hallucinations 1
- Abdominal pains 3
- Getting frightened 4
- Crying much 2
- Fast breathing 1
- Loose stool 1
- Cough 3
- Feeling cold 3
- Child is dull 1
- Whitish appearance in the mouth 1
- vasolidation 1
- Convulsions 1
- **What to do**
- Give panadol 12
- Take to dispensary or hospital 14
- Tepid sponging 7 give aspirin 1
- **what to do**
- take to hospital 11
- reduce clothing for fever 3
- give panadol 3
- keep child warm 3
- give mixed egg with sugar 1
- wash with local herbs e.g. rai before taking to the hospital 3
- tepid sponging 2
- seek advice from the CHWs 1
- give sheep urine 2
- rub on joints onion leaves 1
- tepid sponging with goat milk 1
- grid peas and mix with warm water and bath 1
- give some sugar solution 2
- give an egg 1
- give sheep oil 1
- **diarrhea**
- passing many stools than normal 1
- abdominal pains 5
- loose frequent stools 5
- passing loose watery stools more than 3 times a day 3
- Go to pharmacy 1
- Give water mixed with sugar 1
- Go to a CHW 3
- Reduce clothes 5
- Give water mixed with salt 1
- Wipe child with warm salt water 1
- Buy Fansidar 1
- **pneumonia**
- difficult in breathing 2 = 4
- strange sounds
- convulsions 3
- running nose 4
- cough 8
- vomiting blood 1
- fever 10
- fast breathing 8
- yellow eyes 1
- getting frightened 5
- abnormal increase in weight 4
- watery eyes 2
- dryness of the skin 2
- sunken eyes 1
- eager to drink 1
- dehydration 1
- sunken fontanel 2
- chest in drawing 1
- nasal flaring 1
- crying a lot 2
- sighing 1

- fever 1
- sunken fontanels 1
- watery stool 4
- loose skin 1
- sunken eyes 4
- loss of appetite 2
- sticky saliva 1
- irritability 3
- gas production from the stomach 2
- getting thirsty 1
- dry skin 1
- dehydration 1
- refusal to feed 1
- stinking stool 1
- loss of weight 1
- mucus or blood in stool 1

➤ **what to do**

- give boiled water added salt and sugar 10
- take to hospital-8
- give ORS from CHWs-6
- give boiled rice water-1
- give wheat flour porridge-1
- GIVE ORS –2
- Boiled herbs-1
- Strong tea-1
- Give more fluids-2
- Give fruit juices-1
- Give more porridge-3
- Give pretty of boiled water-1
- Breastfeed more than normal-1
- Seek help from chws-1

**2. Please tell me about child feeding during illness----and after illness**

**(a) How often**

**(b) Types of food**

- give small frequents feeds-5
- give boiled water added with glucose-1
- give sorghum porridge –2
- give fluids –5
- soft foods –1
- give many times in small amounts-2
- give porridge-2
- give water-3
- mashed enriched bananas with milk-2
- give more milk-1
- give green grams –1
- give more times than normal-3
- assisted feeding –1
- semi solid food is the best-2
- give soft food and fluids-1
- continue giving medicine-1
- give enriched food with milk –1
- continue breastfeeding-2

**3. Please tell me the local available foods in this community? Which ones do you use? Why? Which are rich in vitamin A?**

- maize-9
- sorghum –11
- peas-6
- green grams –10
- cowpeas-7
- pampkins-6
- cassava =5
- sweet potatoes-4
- mangoes-7
- pawpaw-9
- lemons-3
- beans –9
- millet –6
- finger –millet-4
- oranges –5
- quavas-2
- bananas-3
- eggs-4
- green vegetables –3

- milk –1
- soyabeans-3
- tomatoes –2
- fish-2
- avocado-1
- passion fruit –1
- **which ones do you use?**
- Maize-7
- Beans –7
- Cowpeas-2
- Pampkins-5
- Sorghum-5
- Pawpaw-5
- Greengram-7
- Soyabean-2
- Sweet potatoes –5
- Mangoes-5
- Fish-1
- Eggs-2

- **Why do you use them?**
  - They are mostly available-7
  - Other foods are scarce-1
  - They are cheap to obtain-3
  - They are nutritious-1
  - They boost blood level-1
  - They give energy-1
  - They protect them from diseases-1
  - They are locally grown-2
  - They thrive well in their farm-1
- **Which ones are rich in vitamin A?**
  - Green vegetables-9
  - Pumpkins-5

- Eggs-1
- Carrots-1
- Fish-1
- Tomatoes-2
- Green grams-3
- Pawpaws-7
- Yellow sweetpotatoes-2
- Mangoes-3
- Beans-3
- Oranges-2
- Sorghum-1
- Millets-1
- Peas-1

#### 4. When and how do you wash your hands? Why?

- Basic - water
- After going to the toilet-9
- Before preparing food – 5
- Before feeding a baby – 9
- After work - 2
  - **What they use**
    - Water and soap-9
    - Warm water-5
    - Salty water-2
    - Ash –3

- Dettol (antiseptic)-1
- Soap or ash –1
- Lemon juice-1
- Sand-1
- **Why?**
  - To prevent germs-3
  - Prevent diseases-4
  - Clear dirt-4
  - Is a routine-1

#### 5. Please how do you feel about health education sessions

- They are helpful-5
- Advice on nutrition-1
- Treatment before hospital-5
- Given feedback on children health –2
- Advice on EBF up to 6months-5
- Taught baby care-6
- **Where do you attend health education sessions?**
  - Chiefs baraza
  - Women groups-2
  - Gm sites-5
  - Health centers –1
  - Public meetings-1
- **How does your family benefit?**
  - Prevention of diseases-3
  - Reduction of diseases-1
  - Reduced malaria incidences-2
  - Baby care on nutrition-2
  - Use of clean utensils-2
  - Advised on use of available foods-2
  - Clean environmental-burning waste-1
  - Boiling of drinking water-2
  - Covering of cooked food-2
  - It is free and no transport used to the venue-1
  - Importance of vitamin A after 6 months-2
- **How do you use the information you receive at home?**
  - Educate those at home-1

- To learn more on hygiene-1
- For environmental cleanliness-1
- Nutrition improvement-1
- How to start a kitchen garden-1
- **What are the constraints?**
  - Lack of required foods-4
  - Ignorance-5
  - Poverty –4
  - Illiteracy-1

- Laziness-1
- Women overworked-2
- Lack of water-1
- **How do you feel about the teaching methods and style of the CHWs**
  - Good-4
  - Questions well answered-3
  - Improved clinic attendance-2
  - EBF and importance of the practice-2
  - CHWs are Close to us and available-1
  - Language used by CHWs is well understood.-1
  - They conduct individual teaching during home visit.-1

**6. Is there anything else you would like us to discuss?**

- **Future plans**
  - Our future plans hampered by poverty-1
  - Formation of MTMSG-2
  - Group formation to support one another-1
  - Planning to plant more paw paw and mangoes-2
  - Dam construction for water catchment-1
  - Soil conservation for more food production-1
- **Recommendations**
  - Provision for Mobile clinic for ANC and immunizations at gm sites-5
  - More CHWs to be trained-8
  - CHWs to be given more drugs. -4
  - Community members to be educated more on EBF-2
  - Supply of affordable ITNS. -5
  - Environmental spraying for mosquitoes-1
  - Provision of free food and ITNS-2
  - Assistance to sick disabled children-1
  - Provision of free water tanks to curb water problem-1
  - Provide food supplements to underweight children at GM site-7
  - Regular provision of vitamin A at the GM site-1
  - Health education to continue-3
  - Provision of bicycles to CHWs to facilitate easy transport-2
- **Questions**
  - Why MCSP does not provide supplementary feeds like other NGOs?
  - Can MCSP give goats for milk?
  - Could project sponsor some income generating activities?
  - Can MCSP project assist HIV/AIDS orphans?

**Focus group discussion carried out for caregivers**

Supervisory area	Village	No. Interviewed	Gender
Kianjiru /mbita	Ngoci	11	Females
Kianjiru /mbita	Munyori	9	Females
Kianjiru /mbita	Gikiro	7	Females
Kianjiru /mbita	Kirima	9	Females
Makima A	ciamburi	5	Females
Makima A	Kanyonga	9	Females
Mavuria	Ngiori	9	Females
Mavuria	kamurungu	8	Females
Riakanau A	Wango	5	Females
Riakanau A	Nthingine	9	Females
<b>Totals</b>	<b>10</b>	<b>81</b>	

CRS / Mbeere Child Survival Project Midterm Evaluation Report July 25 – August 11, 2005  
Home Visit Checklist

Division: \_\_\_\_\_ Supervision Area: \_\_\_\_\_ Name of Village: \_\_\_\_\_

Name of the leader: \_\_\_\_\_

Name of Recorder: \_\_\_\_\_

Intervention	Yes	No	Comments
<b>1. Malaria</b>			
• Environment			
o Cleanliness			
o Reservoirs			
• Bed net			
o Number of nets in the house			
o Condition - number of time washed since last impregnation?			If washed, what detergent did you use?
o Condition – are there holes in the net?			
o Age of net(s)			
o Impregnated (if yes, when)			
o Over child's bed			
o Did child sleep under it last night?			
o Over mother's bed			
o Did the mother sleep under the net last night?			
o Over other bed (who)			
o Did this person sleep under the net last night?			
<b>2. Diarrhea</b>			
• Environmental Sanitation			
o Where do you wash your hands?			
o Soap or ash			
o Latrine			
o Compound cleanliness			
o House cleanliness			
o Refuse disposal			
o Cooked Food storage			
o Waste water disposal			
• Water			
o Source			What is your water source?
o Storage			
o Do you treat your drinking water?			If yes, how do you treat your water?
<b>3. Health</b>			
• Child Road to Health Card for each child in the household			
o Status (up to date)			
o Growth Monitoring (up to date)			Is the child underweight?
• Ante Natal Card			Card taken away?
o Currently pregnant?			
<b>4. Nutrition</b>			
• Food availability			
• Food present (kinds)			
• Observation of breastfeeding			
• Observation of child feeding			

CRS / Mbeere Child Survival Project Midterm Evaluation Report July 25 – August 11, 2005  
**SUPERVISORY CHECKLIST FOR CHWS**

Supervisory area _____ Village _____	YES	NO	COMMENTS
<b>STANDARD</b>			
Welcomes the mother.			
Salter scale balanced to zero before weighed			
Caretaker asked to undress child			
Child's weight taken correctly			
Child's weight correctly plotted on Road to Health Card			
Plotted weight point properly joined to form a growth curve			
Care taker informed on the child's weight status			
Counsel the caretaker based on relevant child's weight status			
Ability to detect other anomalies			
Ensure that the caretaker understands and interprets correctly the child growth curve			
Child's weight and status entered on the child's health register			
Confirms all weight classification are correctly done			
Defaulter follow-up			
Checks the child's health card for Vitamin A Supplementation			
Return date given			
Plans home visit with mothers with children underweight			
Was malnourished(3 consecutive underweight readings) child referred to clinic			
Title of the health education given			
Key messages correctly covered			
Methodology used			
<b>ORS PREPARATION PROCEDURE</b>			
CHW able to check expiry date			
CHW able to measure the amount of water and mix ORS			
CHW able to advice the caretaker on ORS			
<b>ITN TREATMENT</b>			
Did the CHW put on the gloves before the procedure			
Checks the expiry date of the powertab			
Measures correctly the amount of water			
CHW stirs the tablet in water completely			
Able to correctly dip the ITN			
ITN correctly spread after dipping			
Gives correct information on re-dipping			

## Annex 5

## Field Work Logistics

Monday, August 1, 2005 MWEA	Tuesday, August 2, 2005 GACHOKA	Wednesday, August 3, 2005 GACHOKA	Thursday, August 4, 2005 MWEA
<p><u>Embu</u> PHMT (Della, Alfonso - George) – 12:00</p> <p><u>Siakago</u> DHMT (Della, Alfonso – George) – 2:00</p> <p><b>11:00 AM – 1:00 PM</b></p> <p><u>Riakanau B</u> Facility (Riakanau Dispensary) DHC – FGD (Rose, Bob)</p> <p>ORT Corner Observation (Rose, Bob)</p> <p>Community (Nthingini) Caregivers – FGD (Joseph, Amon, Rachael)</p> <p>Community (Wango) Caregivers – FGD (Domisiano, Florence, Lilian)</p> <p>Community (Kilia) CHW (&amp; CF) – Discussion (Paul, Martha, George)</p> <p>Community (Kilia) CHW &amp; Caregiver – Observations (Tom, Vincent, Virginia)</p> <p>Community (Riakanau Market) Home Visits (Jackson, Gilbert, SG)</p> <p><b>PM 3:00 – 5:00 PM</b></p> <p>Team meeting on Tools</p> <p><u>Embu</u> DOE - Development Coordinator Meeting- 5</p> <p>Meeting 8:00 – 9:00 PM</p>	<p><b>AM 10:00 - Noon</b></p> <p><u>Kianjiru/Mbita</u> Facility (Nganduri Dispensary) DHC – FGD (Rose, Bob)</p> <p>ORT Corner Observation (Rose, Bob)</p> <p>Community (Munyori) Caregivers – FGD (Joseph, Amon, Rachael)</p> <p>Community (Kirima) Caregivers – FGD (Domisiano, Florence, Lilian)</p> <p>Community (Nganduri Chief Camp) CHW (&amp; CF) – Discussion (x 2) (Paul, Gilbert) (George, Virginia)</p> <p>Community (Nganduri Chief Camp) CHW &amp; Caregiver – Observations (Tom, Vincent)</p> <p>Community (Kamunyange) Home Visits (Jackson, Martha, SG)</p> <p><b>PM 2:00 – 4:00 PM</b></p> <p><u>Kianjiru/Mbita</u> Facility (Kiritiri HC) DHC – FGD (Rose, Bob)</p> <p>ORT Corner Observation (Rose, Bob)</p> <p>Community (Kanothi) Caregivers – FGD (Joseph, Amon, Rachael)</p> <p>Community (Gikiro) Caregivers – FGD (Domisiano, Florence, Lilian)</p> <p>Community (Mutus) CHW (&amp; CF)– Discussion (Paul, Gilbert, George)</p> <p>Community (Mutus) CHW &amp; Caregiver – Observations (Tom, Vincent, Virginia)</p> <p>Community (Minuri) Home Visits (Jackson, Martha, SG)</p> <p>Meeting 8:00 – 9:00 PM</p>	<p><b>AM 10:00 - Noon</b></p> <p><u>Mavuria</u> Facility (Machanga Dispensary) DHC – FGD (Rose, Bob)</p> <p>ORT Corner Observation (Rose, Bob)</p> <p>Community (Kamurugu) Caregivers – FGD (Joseph, Amon, Rachael)</p> <p>Community (Ngiori) Caregivers – FGD (Domisiano, Florence, Lilian)</p> <p>Community (BI) CHW (&amp; CF) – Discussion (x 2) (Paul, Gilbert) (George, Virginia)</p> <p>Community (BI) CHW &amp; Caregiver – Observations (Tom, Vincent)</p> <p>Community (Rugogwe) Home Visits (Martha, SG)</p> <p><u>Gicheche/Kithunthiri</u> (VCT/PMTCT) Della, Alfonso, Jackson</p> <p><b>PM 2:00 – 4:00 PM</b></p> <p><u>Karaba</u> (VCT/PMTCT) Della, Alfonso, Jackson</p> <p><u>Makima A</u> Facility (Makima Dispensary) DHC – FGD (Rose, Bob), ORT Corner Observation (Rose, Bob)</p> <p>Community (Makima Village) Caregivers – FGD (Joseph, Amon, Rachael)</p> <p>Community (Kanyonga) Caregivers – FGD (Domisiano, Florence, Lilian)</p> <p>Community (Makima Chief Camp) CHW (&amp; CF)– Discussion (Paul, Gilbert, George)</p> <p>Community (Makima Chief Camp) CHW &amp; Caregiver – Observations (Tom, Vincent, Virginia)</p> <p>Community (Kamunyagia) Home Visits (Martha, SG)</p>	<p>Return to Nairobi</p> <p>Begin data compilation and translation</p>

## **Annex 6**

### **Feedback with Partners after Final Presentation**

#### **After the presentation, discussion ensued on the following topics:**

- Need to establish linkages with others working on HIV/AIDS in the same area. Pediatric Aids Foundation starting a project at the provincial hospital in Mbeere District. Curriculum has been developed for pediatric health care workers for follow up with HIV positive kids. Less than 1,000 kids are currently getting ARTs, however the need is currently around 40,000.
- The MOH has a provision for training new DHC members, however budgeting is a problem on and off. While the program exists, it will assist with the training. But for sustainability the MOH needs to be able to do this into the future.
- Integration needs to happen with other programs regarding food security.
- The health facility staff in charge need to be included in the CHC training for sustainability.
- Need to train more health workers on IMCI
- Operations research needs to be done on home based care, orphans and vulnerable children, PMTCT and follow up care.
- Salary for the Diocese staff is fair – in comparing all the different Diocese programs with each other, but need to consider cost of living adjustment (COLA) annually, and the Development Coordinator needs to take action regarding salary levels. The Diocese policy on salaries, medical coverage, and on airtime for cell phones needs to be reviewed. The previous Diocese Needs Assessment needs to be revisited to ensure that the recommendations are being addressed.
- There is a need to review the transportation allowance (upwards) for the CHWs and the CFs.

#### **The MCSP staff responded to the above, and made additional comments:**

1. The MTE helped us see our gaps
2. The MOH really participated with us
3. The MOH has appreciated our efforts on the ground
4. It was good, I liked the sharing
5. The gaps and recommendations was good – it's good that something will be done.
6. The presentation was good, and it flowed very well
7. The MOH was represented from all levels
8. The participants were very objective and sincere, and they were serious about seeing the program succeed. They even gave us suggestions about how to do some things in the field.
9. It was very neat that we were all at the same level – we were able to share regardless of our positions, from the extension worker to the head of the program, we were all equal.
10. To achieve for the goodness of the community, everybody needs to be involved.
11. All the questions were well answered, and we came up with some good recommendations.
12. I appreciated accompanying you to this place and in the MTE. In the presentations the message coming out real clear was that the project is very good at what we are doing. It felt good that the participants also recognized that we are doing well, and they said so,



and that felt great. We are not complete by ourselves, we are a good team and we learn from each other and depend on each other. We must accept each other's strengths and weaknesses. I'm sure we are going to succeed in our targets.

13. The presentation was good. It was very educational. People were open to sharing with each other, especially the MOH staff who are able to advise us on the technical issues on the ground. I really appreciate the way the MOH is really supporting us on the ground. I never realized how much our activities are really appreciated by the MOH. This is a learning process and we need to continue to become empowered. I was really fearing coming here and presenting to people. I congratulate Della Dash and the DOE for bringing us together for this activity. It has been a wonderful learning activity for us all. You grouped us together and made us do presentations in front of everyone and you were encouraging us to learn and grow. This is a wonderful opportunity. Today the Development Coordinator said that this was a great, great thing – I've never seen an evaluation that involved the community so much.
14. This last 2 ½ weeks has given us confidence. In the beginning we were afraid to say anything. When we sent the presentation to Della we were holding our breath, but it went so well and she said we did great – and we appreciate it.
15. We should thank the drivers and the people who gave us lunch every day, the cooks did a very nice job.

**Annex 7**

**Diskette with Electronic Copy of this Report in MS WORD**

## **Annex 8**

### **Special Reports**

1. Catholic Diocese of Embu Individual and Institutional Needs Assessment Report, April 2003
2. Report on the Follow-Up of the IMCI Trained Health Workers in Mbeere District, September 2003
3. CRS Mbeere Child Survival Project First Annual Report, September 2003
4. The Second Mbeere District Case Management Training Course on The Integrated Management of Childhood Illness (IMCI), February 2004
5. Perceptions and Practices of Breast Feeding in Mbeere District, Kenya: A Qualitative Study, April 2004
6. Mbeere Child Survival Project Management Information System Workshop Report, May 2004
7. Mbeere Child Survival Project Report of Technical Exchange Visit to Toso World Vision Child Survival Project, July 2004
8. CRS Mbeere Child Survival Project First Annual Report, September 2004
9. Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) Supportive Supervision Report, November 2004
10. Mbeere Child Survival Project Health Facility Assessment, June-July 2005

**Annex 9**

**Project Data Sheet Form (updated)**